THE EVALUATION OF AN ACCREDITATION PROGRAMME FOR QUALITY IMPROVEMENT IN PRIVATE PHYSIOTHERAPY PRACTICE IN SOUTH AFRICA

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Declaration

I, the undersigned, hereby declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

SUMMARY

"Quality" has different meanings to different people. Even quality experts do not agree on a single definition: Juran's definition of quality revolves around his concept of "fitness for use", Crosby defines quality in terms of performance that produces "zero defects" and Deming defines quality as a "never ending cycle of continuous improvement". One element, however, that is common to all three approaches is that management must accept and demonstrate leadership if quality is to be achieved.

Quality is rarely thought of as others perceive it. What is apparent is that if providers of care wish to maintain leadership in defining quality, they need to

- Actively participate in the public debate about quality.
- Review the way in which they have been defining quality.
- Question whether their definitions are aligned with what the purchasers of health care define as being important.
- Develop meaningful measures of quality and data collection systems that will allow them to demonstrate quality and value.
- Willingly share data not only on outcomes, and also measures that are specific to individual procedures and service providers.

The PhysioFocus practice accreditation programme attempted to achieve the above factors. By realising the goal of the research this was determined.

The goal of the research was to evaluate the PhysioFocus practice accreditation programme and to make recommendations on the educational programme for accreditation in private physiotherapy practices. This goal was realised by means of an exploratory and descriptive research design with a qualitative orientation. The evaluation of the PhysioFocus practice accreditation programme was performed by means of a validated evaluation instrument. The group interview revealed components of the PhysioFocus practice accreditation programme that require remediation. Recommendations included professional-ethical issues, business management and legislative

issues. The recommendations will be implemented by the PhysioFocus practice accreditation committee.

The PhysioFocus practice accreditation learning programme was evaluated by means of a semi-structured questionnaire, containing eleven questions and a section for comments. The general consensus was that the PhysioFocus practice accreditation programme is essential in private physiotherapy practice in South Africa. The implementation of the PhysioFocus practice accreditation programme resulted in the facilitation of quality physiotherapy; professional and personal development; monitoring of quality improvement processes; and the evaluation and remediation of these processes. This supported the central theoretical assumption of the research. Concerns were voiced about the lack of standards, lack of quality improvement skills, the public image of the physiotherapy profession and the lack of basic business management training.

The researcher concluded that the implementation of the PhysioFocus practice accreditation programme is essential in private physiotherapy practice in South Africa. At present the current PhysioFocus practice accreditation programme does not address all the needs of private physiotherapy practices.

Recommendations based on the research included remediation of the current PhysioFocus practice accreditation programme, formal education included business management, professional-ethical-legal issues, standards and scientific methods to analyse process variation and the development of improvement strategies in quality improvement. Other recommendations include informal education, physiotherapy management and structured quality improvement activities. The issue of the image of the professional physiotherapist was also addressed. Topics for future research were identified.

The uniqueness of the research lies in the fact that this is the only physiotherapy practice accreditation programme implemented in South Africa.

It is also the only physiotherapy practice accreditation programme in South Africa that has been evaluated.

OPSOMMING

"Gehalte" het verskillende betekenisse vir verskillende mense. Selfs kenners op die gebied van gehalte stem nie saam met 'n enkele definisie nie. Juran se omvattende definisie is "gebruikswaarde", terwyl Crosby gehalte in terme van produksie, naamlik "zero defek", definieer. Deming definieer gehalte as "'n nimmereindigende siklus van voortdurende verbetering". Die een aspek wat al drie die kenners egter gemeen het, is dat bestuur leierskap moet aanvaar en demonstreer indien gehalte bereik wil word.

Geen twee persone ervaar gehalte eenders nie. Indien diensverskaffers leiding wil behou ten opsigte van gehalte-definiëring, sal hulle verplig wees om:

- aktief deel te neem aan openbare debat oor gehalte;
- die aanvaarde definisie van gehalte te herevalueer;
- die aanvaarde definisie van gehalte op te weeg teenoor dié van die mediese hulpfonds-administrasie;
- gehalte- en data insamelingsisteme te ontwikkel om gehalte en waarde te bewys; en
- gewillig alle data te deel - nie net uitkomsdata nie, maar ook data wat spesifiek op individuele prosedures en diensverskaffers van toepassing is.

Die PhysioFocus praktyk-akkreditasieprogram het gepoog om bogenoemde te bereik. Die navorsing het gerealiseer deurdat die doelstelling bereik is.

Die doelstelling van die navorsing was om die PhysioFocus praktyk-akkreditasieprogram te evalueer en aanbevelings te maak vir 'n leerprogram vir die akkreditasieprogram. Die doelstelling het gerealiseer deur 'n verkennende en beskrywende navorsingsontwerp vanuit 'n kwalitatiewe oriëntasie. Die evaluering van die PhysioFocus praktyk-akkreditasieprogram het deur middel van 'n gevalideerde evalueringsinstrument geskied. Die groepsonderhoud het areas van die PhysioFocus praktyk-

akkreditasieprogram wat remediëring benodig, geïdentifiseer. Aanbevelings het professionele-etiese aspekte, besigheidsbestuur en wetlike aspekte ingesluit. Die aanbevelings sal deur die PhysioFocus praktyk-akkreditasiekommitee geïmplementeer word.

Die evaluering van die PhysioFocus praktyk-akkreditasieleerprogram het deur middel van 'n semi-gestruktureerde vraelys met 11 oop vrae, tesame met 'n afdeling vir opmerkings, geskied. Die algemene aanname was dat die PhysioFocus praktyk-akkreditasieprogram noodsaaklik is in privaat fisioterapiepraktyk in Suid-Afrika. Die implementering van die PhysioFocus praktyk-akkreditasieprogram het gehalte fisioterapie, professionele en persoonlike ontwikkeling, die monitering van gehalteverbeteringsprosesse, asook evaluering en remediëring van hierdie prosesse, tot gevolg gehad. Dit het die sentraalteoretiese aanname van die navorsing ondersteun. Daar was egter kommer oor die gebrek aan standaarde, die beeld van die fisioterapieprofessie, asook die gebrek aan besigheidsbestuuropleiding.

Die navorser het tot die gevolgtrekking gekom dat die implementering van die PhysioFocus praktyk-akkreditasieprogram noodsaaklik is in privaat fisioterapiepraktyk in Suid-Afrika. Die huidige PhysioFocus praktyk-akkreditasieprogram voldoen nie aan al die vereistes van privaat fisioterapiepraktyk in Suid Afrika nie.

Aanbevelings vanuit die navorsing sluit die volgende in: remediëring van die huidige PhysioFocus praktyk-akkreditasieprogram; formele opleiding, insluitende profesionele-etiese-wetlike aspekte; standaarde; wetenskaplike metodes om die praktykprosesveranderinge te analiseer; en die ontwikkeling van 'n gestruktureerde gehalteverbeteringstrategie. Die beeld van die fisioterapieprofessie is ook aangespreek. Onderwerpe vir toekomstige navorsing is geïdentifiseer.

Die navorsing is uniek omdat die PhysioFocus praktyk-akkreditasieprogram die enigste akkreditasieprogram vir fisioterapie in Suid Afrika is. Dit is ook die enigste fisioterapie-akkreditasieprogram wat in Suid Afrika geëvalueer is.

For David Maurice

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Chapter One

Overview of the Research

There are no national frontiers to learning (JAPANESE PROVERB).

1.1. INTRODUCTION

The goal of the research is to evaluate an accreditation programme for quality improvement in private physiotherapy practice in South Africa. The process will include an education programme to facilitate the implementation of the programme. To qualify for accreditation, a practice must comply with five standards, namely:

- Organisation and Administration
- Staff Development and Direction
- Policies and Procedures
- Facilities and Equipment and
- Quality management (PhysioFocus, 1998).

The development of an accreditation programme in physiotherapy that uses structure, process and outcome standards should address the improvement of quality in physiotherapy. The quality improvement process could be very useful in the evaluation of the programme.

Although the South African Bureau of Standards (SABS) began formulating standards in 1975, the concepts of quality improvement, accreditation and standards in health care, have only been addressed in South Africa during the last eight years. According to Van Der Merwe (1994: 4) "The formulation of standards is one of the first steps in quality improvement. It is important that health care workers are responsible for the formulation of the standards that are congruent with their and their team's concepts of quality health care. Thus, these standards evolve from present practice, and the responsibility assumed, enhances the professional experience of sense and meaning of their roles". The main aim of writing standards is to maintain acceptable standards in physiotherapy practice, to indicate areas where improvement should/could occur, and to monitor the quality of physiotherapy practice. Practice accreditation will give practitioners due recognition for meeting high standards

in private physiotherapy practice. In the process of raising and maintaining standards, both principals of practices and their staff could learn new organisational skills. The programme should be entirely voluntary. Participating practitioners should demonstrate their willingness to be responsible for the evaluation and elevation of their practice standards and, ultimately, the quality of care offered to the public.

In the health care industry, world trends have been moving towards quality improvement programmes and accreditation of health care services. According to Juran (1989), there are three quality related processes, namely: **quality planning** which will determine who the customers are and determine their needs. This leads to the development of products to address these needs, setting goals and implementation of the products, **quality control** which implies evaluation of the quality performance, comparing the actual performance to the quality goals and then acting on the differences, and **quality improvement** which is the establishment of an infrastructure to evaluate the quality improvement on an annual basis.

In South Africa all practicing physiotherapists are bound by law to register with the Health Professionals Council of South Africa. Professionally it is also expected for practicing physiotherapists to belong to the South African Society of Physiotherapy (SASP). Membership of the SASP is not compulsory. The SASP consists of several sub- or interest groups of which PhysioFocus, the Private Practitioners Association of the SASP, has the greatest membership, namely 1300 members. Not all physiotherapists working in the private sector, are members of PhysioFocus, as many are employees in private practices.

According to the 2001 SASP membership figures, more physiotherapists are employed in the private sector than in the public/government sector in South Africa. There are many reasons for this situation, the most common being lack of posts and perceived poor remuneration packages. The scope of physiotherapy in both the private and the public sectors is the same, with the same hospital services offered by both groups. Private practices that offer their

services to private hospitals are not employed by the hospitals, but work there on a referral basis. The practitioners may or may not rent rooms from a given hospital and also treat patients who are not necessarily referred by health professionals working in the hospital.

In private practice, the principals of the practice are solely responsible for the total management and reputation of the practice. As such, they are in charge of the ethics, marketing, quality of treatment, treatment regimens, scope of services offered, account rendition, financial management, staff recruitment and training, and general running of the practice.

Van der Merwe (1994: 1) states that service rendering is a service commitment because the service is rendered to persons and the community. Because of this service commitment, quality should be the motive of this service rendering. Health care practitioners are independent practitioners providing professional and personal accountability for their actions and omissions in clinical practice. The health care manager is responsible for the managerial aspect of quality improvement, cost-effective use of resources and management of personnel. In personnel management, the manager is responsible for the provision, utilisation, retention and development of personnel. The manager needs to be constantly aware of internal and external factors that might influence the stresses placed on personnel.

Quality implies that professionals work according to specific standards that are set by the professionals who have to implement these standards. These standards form part of an accreditation programme. Van der Merwe (1994:10) states further that it is important for health care professionals to take ownership of the formulated standards, in keeping with each profession's understanding of quality improvement. This will enhance the effectiveness of the implementation of such standards. Professionals involved in the formulation of such standards increase their own experience and aims of their specific profession in the health care industry.

Quality improvement programmes are internal methods of evaluating the quality of health care being rendered, whereas accreditation implies external mechanisms to evaluate compliance to these standards. Accreditation gives practitioners due recognition for meeting high standards in private practice. In the process of raising and maintaining practice standards, principals of practices are educated in new management and organisational skills. Principals must demonstrate an ongoing commitment to quality management and continuing education during their practice's accreditation term by providing evidence of compliance with these standards, both on the survey of the practice, as well as on re-application (PhysioFocus, 1998).

Accreditation as part of quality management is a philosophy that seeks continuous improvement in performance of processes, products and services. It is also known as continuous quality improvement and total quality management (PhysioFocus Accreditation Programme, 1998). It can be described as the process of ensuring that physiotherapy services are of the highest attainable standard and are continually improving. This involves the balance between meeting the needs and expectations of internal and external customers with appropriate cost-effective delivery of service. The term 'quality activities' is used to describe activities undertaken in the practice that identify problems for correction and opportunities for improvement in the delivery of patient care.

Quality improvement and management strategies systematically review and evaluate current work practices, outcomes of care and aspects of the administration of the private practice with the view to identifying trends, establishing protocols and procedures, resolving problems and continuously improving the performance of the private practice. Regardless of the scope and parameters of a private practice, there will always be a role for the formal review of services provided by the private practice (PhysioFocus, 1998).

The accreditation programme to be implemented by PhysioFocus will provide training on accreditation on a national level. In-house training will be regarded as an essential component of the accreditation programme. The first step in an

accreditation programme is the formulation of standards. These standards should comply with national and professional regulations.

The passing of the South African Qualifications Authority Act (SAQA), No 58 of 1995 (Republic of South Africa [RSA], 1995) has enabled South Africa to develop its own National Qualifications Framework (NQF). The NQF has set clear standards for all types of learning and has established quality management systems to ensure that the set standards are implemented (Philips, 1997a). The foundation for learning set up by SAQA and the NQF has been designed to allow scholars/trainees/students to earn credits towards national qualifications. Providers of learning include schools, colleges, technikons, universities, in-house training or practical experiences. These credits are in the form of "Qualification Unit Standards" registered by SAQA. This system brings together the following:

- qualifications already in existence;
- a structure to which new qualifications can be added;
- all qualifications (new and old) meeting the specified, clearly defined quality requirements; and
- the development of current and future international education and business networks and opportunities.

1.2. PROBLEM STATEMENT

In researching the available literature, no references to accreditation programmes in physiotherapy were found. However, references to accreditation activities were found in the related field of nursing (Hanna, Wolford & James, 1998: 113-116; Grimaldi, 1998:14-17; Dianis & Cummings, 1998: 49-59; Cooper, 1998: 30-35; Popovich JM, 1998: 14-21; Popovich ML, 1998:115-117; Macklin & Mathews, 1997: 60-62; Horton, 1997: 23-28; Clarke & Warr, 1997: 1235-1242; Wilson, 1997: 20; Powell, 1997: 755). Accreditation activities are in an early stage of implementation in South Africa. At present education is at the forefront of this development and the education system is changing to a system which will be accredited by the South African Qualifications Authority (SAQA).

In 1994 PhysioFocus, the Private Practitioners Association of the South African Society of Physiotherapy (SASP) unanimously decided to embark on a practice accreditation programme for physiotherapists in private practice. The programme developed by the Australian Physiotherapy Association was acquired in 1996 after deciding that it would be too time consuming and costly to develop a new programme. This programme was adapted to suit the private practice situation in South Africa, bearing in mind registration requirements, building regulations, fire regulations and electrical requirements as laid down by the South African Bureau of Standards (SABS).

This task was completed in 1997 at exactly the same time as the Australian version was updated. The PhysioFocus Accreditation Committee decided to purchase the update and incorporate this into the final South African version. This task was completed in 1998 and the programme was ready for implementation from June 1999.

When PhysioFocus implemented the accreditation programme, no formal learning programme for the accreditation process, was available. Training on the aspects of the accreditation programme was offered at PhysioFocus meetings. According to SAQA, PhysioFocus should act as a provider of training as the implementation of the accreditation programme provides an opportunity for education/learning in quality improvement as in-service training.

The South African government has taken a transformational approach to education to ensure that scholars/trainees/students gain the knowledge, skills and values that will allow them to contribute to their own success as well as to the success of their family, community and the nation as a whole (Department of Education, 1997a: 10).

The South African government implemented a number of structures, guidelines and criteria to facilitate the transformational approach to education. The process of transformation is described in Chapter two according to the appointment of the South African Qualifications Authority (SAQA); the development of critical cross-field outcomes; the identification of fields of learning/content clusters; the

identification and/or formulation of specific outcomes; the formulation of assessment criteria, range statements, and performance indicators; the development of learning programmes/curricula; the formulation of instructional programmes according to identified and formulated learning outcomes; continuous assessment of scholar/trainee/student progress according to the learning outcomes stipulated; and the assessment of education and learning by accredited bodies.

The National Standards Bodies (NSBs) and the Education and Training Quality Assurance bodies (ETQAs), are the two institutional pillars of SAQA. NSBs for 12 organising fields of learning were registered and the applications for accreditation of the NSB for physiotherapy have been received by SAQA. As a starting point all existing qualifications offered in South Africa must be recorded in the interim register (SAQA, 1997; 1998a).

The Department of Education White Paper 3 of July 1997 stated that the challenge in South Africa is to redress past inequalities and to transform the higher education system to serve a new social order, to meet pressing national needs, and to respond to new realities and opportunities (DoE, 1997b).

The most significant conceptual change is that the single co-ordinated higher education system will be premised on a programme-based definition, namely that higher education comprises all learning programmes leading to qualifications higher than the proposed Further Education and Training Certificate. According to SAQA (SAQA, 1998b: 1), the Higher Education Act No. 101 of 1997 stated that all institutions, public and private, have to be registered with the Department of Education to operate legally. The process for registration of qualifications included recording of existing qualifications before 30 June 1998 to gain interim registration. To maintain recorded qualifications, these had to be submitted in the required format by 30 June 2000 in order that an interim registration be extended until June 2003. PhysioFocus is not registered with the Department of Education, but the original qualification in physiotherapy is registered through the various higher educational institutions. The accreditation and learning programme will facilitate the updating of

professional knowledge and skills. This will form part of the required continuing education programmes.

The SAQA Act, effective from October 1995, enables South Africa to develop its own National Qualifications Framework (Philips, 1997a: 1). The SASP, and therefore PhysioFocus as well, will be registered with SAQA and will adhere to the SAQA philosophy and standards. For further discussion on SAQA and NQF see Chapter two.

As noted in the introduction, the proposed PhysioFocus practice accreditation programme was adapted from the Australian Physiotherapy Association Accreditation Programme. This adapted accreditation programme has to date not been validated. The guidelines are therefore not scientifically based in private physiotherapy practice in South Africa. The question therefore whether the PhysioFocus practice accreditation programme comply with all the requirements in the South African private physiotherapy practice.

Private practitioners have not received formal education in the implementation of an accreditation programme and a need for this was identified. The question therefore also arises whether the learning programme for accreditation is adequate and effective for implementation of the PhysioFocus practice accreditation programme in private physiotherapy practice.

From the above, the goal of the research, the central theoretical assumption and outcomes are described in the following sections.

1.2.1. Goal of the Research

The research goal is to evaluate the PhysioFocus accreditation programme and to make recommendations on the learning programme for accreditation in private physiotherapy practices.

The objectives of the research were divided into three phases, namely:

- Phase one: to explore the literature on accreditation and quality physiotherapy practice in order to identify empirical indicators for the development of a provisional evaluation instrument for the PhysioFocus practice accreditation programme;

- Phase two: to identify remedial actions to be implemented in the learning programme for accreditation in private physiotherapy practices. This phase was conducted by means of an open-ended, semi-structured questionnaire (see Appendix three) which was completed by the physiotherapists in the target population. The results were analysed and recommendations made; and

- Phase three: to evaluate the accreditation programme implemented in selected voluntary private physiotherapy practices. A provisional evaluation instrument (see Appendix one) was formulated according to the empirical indicators identified in phase one. The provisional evaluation instrument was sent to the physiotherapy experts for validation. The recommendations from the expert physiotherapists were implemented and a final evaluation instrument (see Appendix two) formulated. The final evaluation instrument was utilised to evaluate the PhysioFocus practice accreditation programme.

1.2.2. Central Theoretical Assumption

In qualitative research the hypothesis is replaced by the central theoretical assumption. These assumptions are statements about the research domain which form part of the existing theory of the discipline or related disciplines. Theoretical assumptions give form to the central theoretical statements of the research and form the framework for the epistemic statements of the research (Botes, 2000). The evaluation of the accreditation learning programme for quality improvement in private physiotherapy practice in South Africa should facilitate:

- quality physiotherapy practice;
- professional and personal development;
- monitoring of the progress of the pre- and post accreditation process; and
- monitoring and remediation of continuous changes in private physiotherapy practice.

1.2.3. Outcome of the Research

The outcome of the research will have the following as result:

- a validated accreditation programme for private physiotherapy practice in South Africa according to SAQA;
- recommendations for inclusion in the training manual, which should facilitate the training of prospective candidates and practice surveyors for accreditation in private practice.

1.3. THE RESEARCH MODEL

In this research the researcher utilised the Botes Research Model (1998; 2000: 9), which consists of three orders. The double reference to the Botes Model, refers to the documentation of the Model in 1998 and the refinement of the Model in 2000. This model is practice orientated and specifies that all research should lead back to the practical situation. Botes (1995) emphasizes that trustworthiness remains a criterium for good research. Trustworthiness relates to justification, which is also an important issue in qualitative research. The model proposed by Botes (1998; 2000: 9) provides a framework for the justification of research. The framework for research decisions is formed by the so-called determinants of research.

The research model is based on the theoretical perspectives of Mouton and Marais (1990). The assumptions of the model are the following (Botes, 1995):

- The determinants of research provide a framework for the research decisions. These determinants are specific for each individual research project and can be used to justify the research decisions of each individual

research project. The research decisions of the research project must be justified and assessed within its own framework of determinants for research. There must be a logical relationship between the research decisions and the determinants of research.

- The model has an open view (holistic perspective, lending itself to all methodologies) of research design, the methods of data collection, methods of data analysis, methods of sampling, as well as methods of reliability and validity. Once again, all of these research decisions must be justified within the framework of the determinants of research.

- The independent relationship between practice, theory and philosophy is important for the discipline. The aim of research is to give guidelines to improve the practice of the discipline. The model focuses on the research projects of individuals or groups, where these individuals or groups act according to their individual philosophy.

The activities of the discipline are represented in the interaction on three levels or orders in this research model:

- The first level or order is the discipline of health care practice with health care as the activity and the field of research. The characteristics of the health care practice act as the determinants of research decisions. In this research the physiotherapy private practice is the field of research and is regarded as the first order of the model.

- The second level or order is the theory development of health care with research as the activity. The research decisions (initiative, conceptualisation, formulation, research design and implementation) are taken within the framework of the research determinants (characteristics of the research field, assumptions of the researcher, research context and the research objectives). This constitutes the research methodology. These research decisions must be justified within the framework of the determinants of research to comply with trustworthiness of the research. This research is

qualitative in nature. The research strategy is briefly described in section 1.3.1.

- The third level or order is the paradigmatic perspective of the research. On this level the researcher selects assumptions applicable to the specific research based on the researcher's interaction with the practice or the research field. There are three kinds of assumptions namely: *metatheoretical* (these are not testable as they have their origin in philosophy and deal with human beings and society. They do however, influence research decisions throughout). The researcher believes in Judeo-Christian values. All humans are creations of God and have individual needs, namely personal, inter-personal, social and environmental needs. All these needs form part of a holistic being and all humans should be approached in a holistic way and their needs tended to in order to restore their holistic being; *theoretical* (these are testable and contain statements of the research field as well as part of the accepted theory of the discipline. These theoretical assumptions shape the conceptual framework of the research as well as central theoretical statement). In this research the Roper, Logan and Tierney Activities for Living Model (Roper, Logan & Tierney, 2000; Pearson, Vaughan & Fitzgerald, 1996) was used and is described in paragraph 1.3.3. below; and *methodological* (these assumptions are concerned with the researcher's view of the nature and structure of science, and the specific area of practice being researched. These assumptions direct the research design). The researcher has no specific preference, but does, however, accept a functional strategy of reasoning in this research. The researcher supports these assumptions.

1.3.1. Research Design and Methodology

Botes (2000) states that the research decisions that are made in the design phase, deal with the research strategy (overall approach), the methods of data collection, methods of data analysis, the target population and methods of sampling, as well as methods for validity and reliability. The research design and method are described according to the research strategy, models, trustworthiness and strategies of reasoning. The research design and methodology is described in detail in Chapter three.

In this research an exploratory and descriptive design with a qualitative approach was used. In qualitative research more subjective methods are used, as researchers in this field are not interested in causal laws, but in people's perspective as far as beliefs, experiences and personal meaning systems are concerned. By bringing into the equation the perceptions of the interests of the participants themselves, issues are viewed in a way that could not be realised through other techniques (Ritchie, 1999: 253). Phenomena are viewed in their holistic and social context (Brink, 1993: 35). Qualitative researchers are primarily concerned with process, rather than outcomes or products (Creswell, 1994: 145). Kirk and Miller (1986: 9) describe qualitative research as a particular tradition in social science that essentially depends on watching people in their own territory and interacting with them in their own language, on their own terms. Technically, according to Kirk and Miller (1986: 9), a qualitative observation identifies the presence or absence of something. Qualitative research requires personal rather than detached engagement in the context. It requires multiple, simultaneous actions and reactions from the human being (the researcher) who is the research instrument (Meloy, 1994: 68). The qualitative researcher is the primary instrument for data collection and analysis and the research often involves fieldwork. The process of qualitative research is inductive in that the researcher builds abstractions, concepts and theories from detail. Qualitative research methods are descriptive and result in rich, thick, complex and holistic descriptions of participants' subjective experiences (Creswell, 1998: 15).

Esteemed medical journals such as the British Medical Journal and the Lancet have given credibility to qualitative research in the health care environment by increasingly publishing qualitative research. It has brought a welcome paradigm shift to the field of qualitative research in health care (Green & Britten, 1998).

In this research the data is interpreted and reported in the following ways:

- Exploratory: This is research in a relatively unknown field to gain insight and understanding in the problem (Uys & Basson, 1996:38). The literature on

accreditation in physiotherapy and related health care fields was explored extensively.

- Descriptive: This is the methodical collection of accurate data on the domain phenomenon to be studied (Uys & Basson, 1996: 28).

  - An evaluation instrument was developed to evaluate the practice accreditation programme; and

  - A qualitative survey was conducted on all the physiotherapists in private practice in South Africa involved in the implementation of the PhysioFocus practice accreditation programme, via the postal services and personal interviews regarding the PhysioFocus practice accreditation programme learning programme. These physiotherapists are involved in the accreditation process and have worked through the programme and implemented the standards in their own private practices. The survey responses were analysed and interpreted according to qualitative methods.

The evaluation instrument was formulated according to the contents of the accreditation learning programme, including the following aspects: the educational aids for preparation; suitability and applicability of the accreditation programme in private physiotherapy practice; and empirical indicators identified in the literature research.

1.3.2. Research Strategy

The research strategy (overall approach) was directly in line with private practice accreditation in physiotherapy in South Africa and formed part of the second order of the Botes Research Model (1998; 2000: 9), (see Figure 3.1).

In this research the Deming FOCUS-PDSA Model (Kerridge & Kerridge, 2000; Loebig, 2000; Bonstingl, 1996: 59-61; Evans & Lindsay, 1996; Naidoo & McSharry, 1999) was used. PDSA is an acronym for Plan, Do, Study and Act.

The PDSA cycle is used to check the progress in each step of the FOCUS-process continuously. The components of the improvement process FOCUS are:

- ***F*** ind a process to improve;
- ***O*** rganise an effort to work on to improve;
- ***C*** larify current knowledge of the process;
- ***U*** nderstand process variation and capacity; and
- ***S*** elect a strategy for continued improvement.

The implementation of the FOCUS Steps in this research are described fully in Chapter Two. This is briefly described as **f**ind a process to improve, **o**rganise an effort to work on improvement, **c**larify current knowledge of the process, **u**nderstand process variation and capability, and **s**elect a strategy for improvement (see Table 3.5.).

The strategy implemented for the evaluation of the PhysioFocus practice accreditation learning programme was according to a semi-structured questionnaire with open-ended questions.

1.3.3. The Conceptual Framework

The conceptual framework for the research is based on the Model of Activities of Living (Roper et al., 2000; Pearson et al., 1996), the researcher's experience and the literature research. The researcher's experience and the literature research is described in Chapter two. The conceptual framework is part of the third order of the Botes (1998; 2000: 9) model.

The Activities of Living model for nursing and health was developed from the Model of Living (see Figure 3.2.) by Roper et al. (2000). This model was chosen for its clarity as well as its adaptability to other health sciences, such as physiotherapy, as it focuses on factors that influence 'activities of living' and the individualisation of care. This model focuses on the person as an individual as she takes part in living throughout her lifespan, moving from dependence to

independence, according to age, circumstances and environment (Pearson et al., 1996). One of the factors influencing the quality of physiotherapy care, is the all encompassing (holistic) assessment of the patient. The patient is after all the focus of the physiotherapy treatment and therefore also the focus of the accreditation programme. The Activities of Living Model is thus an informal checklist for the evaluation instrument to be utilised in the PhysioFocus practice accreditation programme (see Table 1.1).

Table 1.1. Activities of Living Model (Roper et al., 2000)

Components	Description
1. Activities of Living (AL's)	Twelve activities collectively contribute to the complex process of living. Each activity has many dimensions and complexities. All AL components contribute to another dimension of living.
2. Lifespan	It is relevant to the whole of a person's life as it concerns the period from conception to death. There is continuous change throughout the lifespan and every aspect of living is influenced by the physical, psychological, socio-cultural, environmental and politico-economic occurrences encountered throughout life.
3. Dependence/independence continuum	This component is closely related to lifespan and all the AL's. Each person has a dependence/ independence continuum for each AL.
4. Factors influencing AL's	AL's are carried out in a variety of ways, as well as with differing degrees of independence due to the variety of factors that influence the way AL's are carried out. These factors are physical, psychological, socio-cultural, environmental and politico-economic in nature.
5. Individuality in living	Each person's individuality in carrying out AL's is, in part determined by the stage in the lifespan, degree of dependence/independence as well as the impact of the factors mentioned in four above. Individuality in living is a product of all four the other components.

Although the model refers to individuals, it can also be used in the context of families or larger groupings of the community. This conceptual model is not intended to be inflexible or limiting – it is a tool to assist understanding. The model uses broad concepts that can have wide application. This model is more fully described in Chapter three.

1.3.4. Trustworthiness

To ensure trustworthiness of the research in this research, the researcher used the trustworthiness model described by Lincoln and Guba (1985: 290) and Guba (1981). This model is based on the identification of four aspects of trustworthiness as presented in Table 1.2. below. Trustworthiness is more fully described in Chapter three.

Table 1.2. Trustworthiness (Lincoln & Guba, 1985:290; Guba, 1981)

Aspect of trustworthiness	Definition
"Truth value" / Credibility	This is based on discovery of human experiences as it is perceived and observed by the respondents.
Applicability / Transferability	Refers to the extent in which the findings can be applied in other contexts, within other groups. It is the ability to generalise results with regard to bigger populations.
Consistency / Dependability of data	The results will remain the same during repetition of the evaluation, using the same respondents.
Neutrality / Confirmability in reliability	Implies the freedom of prejudice in the research procedures and results.

1.3.5. Strategies of Reasoning

The strategies of reasoning used in this research are analysis, deduction, induction, derivation and synthesis as briefly summarised in Table 1.3. below. The strategies of reasoning are more fully described in Chapter three.

Table 1.3. Strategies of Reasoning

Strategies of reasoning	Description
1. Analysis	Clarification and refining of objects, assumptions and theories (Wolcott, 1994).
2. Deduction	The process of developing specific predictions from general principles of belief (Abdellah & Levine, 1979).
3. Induction	This is the logical process whereby a probable conclusion, depending on external confirmation, is reached (Creswell, 1994).
4. Derivation	This implies analogies and metaphors during the transposition or redefinition of concepts, statements or theories from one context to another (Walker & Avant, 1988).
5. Synthesis	Isolated parts of theoretical information is combined to construct a new concept or statement (Walker & Avant, 1988).

1.4. SCOPE OF RESEARCH

The scope of this research falls within the context of quality improvement and accreditation and education in private physiotherapy practice in South Africa. This falls within the regulations as set out by SAQA (1995).

1.5. THE POPULATION GROUPS OF THE RESEARCH

The population groups of the research include:

1.5.1. A purposeful literature population on quality improvement, accreditation in physiotherapy practice and education.
1.5.2. The research is limited to physiotherapists in private practice in South Africa according to the following criteria:
1.5.2.1. Registered with the Health Professionals Council of South Africa.
1.5.2.2. A fully paid up member of the South African Society of Physiotherapy.
1.5.2.3. A fully paid up member of PhysioFocus, the Private Practitioners Association of South Africa.
1.5.2.4. PhysioFocus members that have endeavoured to implement the provisional PhysioFocus accreditation programme (including the group of practice surveyors).
1.5.2.5. The group of expert physiotherapists involved in the development of the PhysioFocus practice accreditation programme.

1.6. TERMINOLOGY

The terminology is described to avoid and eliminate misinterpretation and is used in specific context.

Evaluation: 1. To find out or state the value of, to assess (Hawkins, Weston & Swannell, 1992).
2: Form an idea of the amount, number, or value of; assess (Pearsall, 1998).
3. Determining how well a programme or policy is working or reaching its goals and objectives (Neumann, 2000).

Accredit: 1. Officially recognised, certified as being of a prescribed quality (Hawkins et al., 1992).

2. Official, approved, authentic, authorised, certified, legitimate, licensed, trustworthy (Spooner, 1991).

3. Give authority or sanction to someone when recognized standards have been met (Pearsall, 1998).

Validate: 1. Demonstrate or support the truth or value of; actually supporting the intended point or claim; acceptable as cogent; check or prove the validity or accuracy of something (Pearsall, 1998).

2. A term meaning truth that can be applied that can be applied to the logical tightness of experimental design, the ability to generalise findings outside a study, the quality of measurement, and the proper use of procedures (Neumann, 2000).

System of Quality Improvement: The process of value clarification, standard formulation, implementation and evaluation, remediation and re-evaluation.

PhysioFocus, the Private Practioners Association of the SASP: PhysioFocus refers to the members of the SASP who work in private practice and are members of the sub-group, PhysioFocus.

Gender: Where gender is referred to in the text, the feminine form is used.

1.7. ETHICAL CONSIDERATIONS

Participation in this research was voluntary and informed verbal consent was obtained from respondents.

1.8. CHAPTERS OF THE DISSERTATION

In Chapter one the introduction, overview and the problem statement of the research are described to provide an indication for the justification for this research. Chapter two consists of a literature research, which includes the foundations for professional physiotherapy, the legislative framework, outcomes-based education and quality improvement and accreditation. Chapter three describes the research design, research methodology and the development of an evaluation instrument. Chapter four consists of the

description of the data collection, analysis and results. In Chapter five a summary, conclusions, limitations and recommendations are described, based on the literature research and the results of the research.

1.9. PUBLICATION

The preparation of this manuscript is according to the Publication Manual of the American Psychological Association (1994). This includes style, editing, formatting and layout of the manuscript. Referencing was done according to the Harvard method, adopted by the Education Faculty of the University of Stellenbosch.

1.10. SUMMARY

In order to comply with continuing demands for improved quality in the health care environment, it is imperative that an accreditation process for quality improvement in private physiotherapy practice be implemented, continuously monitored and updated in accordance with the changing health care environment and expectations from patients, insurers and funders in the managed health care arena. This research endeavours to facilitate a validated programme for quality physiotherapy practice, professional and personal development, monitoring of the progress of the pre- and post accreditation process, and address the continuing changes in private physiotherapy practice. In Chapter two the literature research on the foundations of professional physiotherapy practice in South Africa, the legislative framework for physiotherapy practice in South Africa, outcomes based education (OBE) and quality improvement which includes accreditation, is described.

Chapter Two

Literature Research

What is so wonderful about great literature is that it transforms the man who reads it towards the condition of the man who wrote, and brings to birth in us also the creative impulse. E.M. FOSTER, "Anonymity: An Enquiry," Two Cheers for Democracy (1951).

2.1. INTRODUCTION

Much of the literature on the subject of quality management and quality improvement has its foundation in the manufacturing or industrial context. Quality theorists started turning their attention to the application of quality principles to the service sectors such as banking, the hospitality industry and to the focus of this research paper, medical care in the 1970's and 1980's (Crosby, 1979; Norman, 1984; Peters & Austin, 1985; Prisg, 1974). Education is also a service industry and these principles are also applicable and adaptable to this context.

The successful private physiotherapists of the new millennium will be characterised as people who are equipped with the necessary knowledge, skills and values/attitudes to adjust readily to multiple challenges within the scope of private physiotherapy in South Africa. They will make, through personal and professional development, a significant contribution to the health services and health needs of the country and the world. The South African government has taken a transformational approach to outcomes-based education (OBE) to ensure that learners gain the knowledge, skills and values that will allow them to enhance their own success, as well as to the success of the nation as a whole (Department of Education, 1997b: 10). Successful implementation of a system of quality improvement and accreditation facilitated by means of continuing education in private physiotherapy practices can empower physiotherapists to challenge this vision to become the successful physiotherapists of the new millennium.

Chapter two forms the first phase of the research in order to realize the first research objective. Chapter two is the inductive and deductive description of the literature research for a system of quality improvement and accreditation in

private physiotherapy practices in South Africa. Step one of the FOCUS-PDSA model in the research methodology is implemented in this Chapter.

2.2. GOAL OF THE RESEARCH

As described in section 1.2.1., the goal of the research is to evaluate the PhysioFocus accreditation programme and to make recommendations on the learning programme for accreditation in private physiotherapy practices. The literature was therefore researched according to the goal of the research.

The objectives of the research were divided into three phases, namely:

- Phase one: to explore the literature on accreditation and quality physiotherapy practice in order to identify empirical indicators for the development of a provisional evaluation instrument for the PhysioFocus practice accreditation programme ;
- Phase two: to identify remedial actions to be implemented in the learning programme for accreditation in private physiotherapy practices. This phase was conducted by means of an open-ended, semi-structured questionnaire (see Appendix three) which was completed by the physiotherapists in the target population. The results were analysed and recommendations made; and
- Phase three: to evaluate the accreditation programme implemented in selected voluntary private physiotherapy practices. A provisional evaluation instrument (see Appendix one) was formulated according to the empirical indicators identified in phase one. The provisional evaluation instrument was sent to the physiotherapy experts for validation. The recommendations from the expert physiotherapists were implemented and a final evaluation instrument (see Appendix two) formulated. The final evaluation instrument was utilised to evaluate the PhysioFocus practice accreditation programme.

2.3. THE CONCEPTUAL FRAMEWORK

The conceptual framework for the research is based on the Model of Living (Roper et al., 2000; Pearson et al., 1996; Aggleton & Chalmers, 2000), the researcher's experience and paradigm (philosophy about life and health); and

the literature research. The researcher's experience and the literature research is further described in this chapter. The conceptual framework is part of the third order of the Botes (1998; 2000) model.

2.3.1. The Researcher's Personal and Professional Experience

The researcher has a four year B.Sc. Physiotherapy degree and M.Sc. at university level and 24 years experience as a practicing registered physiotherapist. This experience includes clinical practice in military and private hospitals, as well as private physiotherapy practice, both in South Africa and abroad. The conditions that were treated include the full spectrum of orthopaedics, neurology and neurosurgery, respiratory and thoracic surgery, cardiovascular diseases and surgery, obstetrics and gynaecology, paediatrics, geriatrics, community care, treatments of physical ailments of psychiatric patients and sports medicine. This includes treatment of patients in intensive care units and rehabilitation with regard to all of the above conditions.

The last 20 years of practice included managerial responsibilities (the charge position of the physiotherapy department in a private hospital, as well as the principal physiotherapist in private physiotherapy practice). The implementation of the processes of planning, organising, leading and control were part of these managerial responsibilities, although these were never included in the basic physiotherapy training degree.

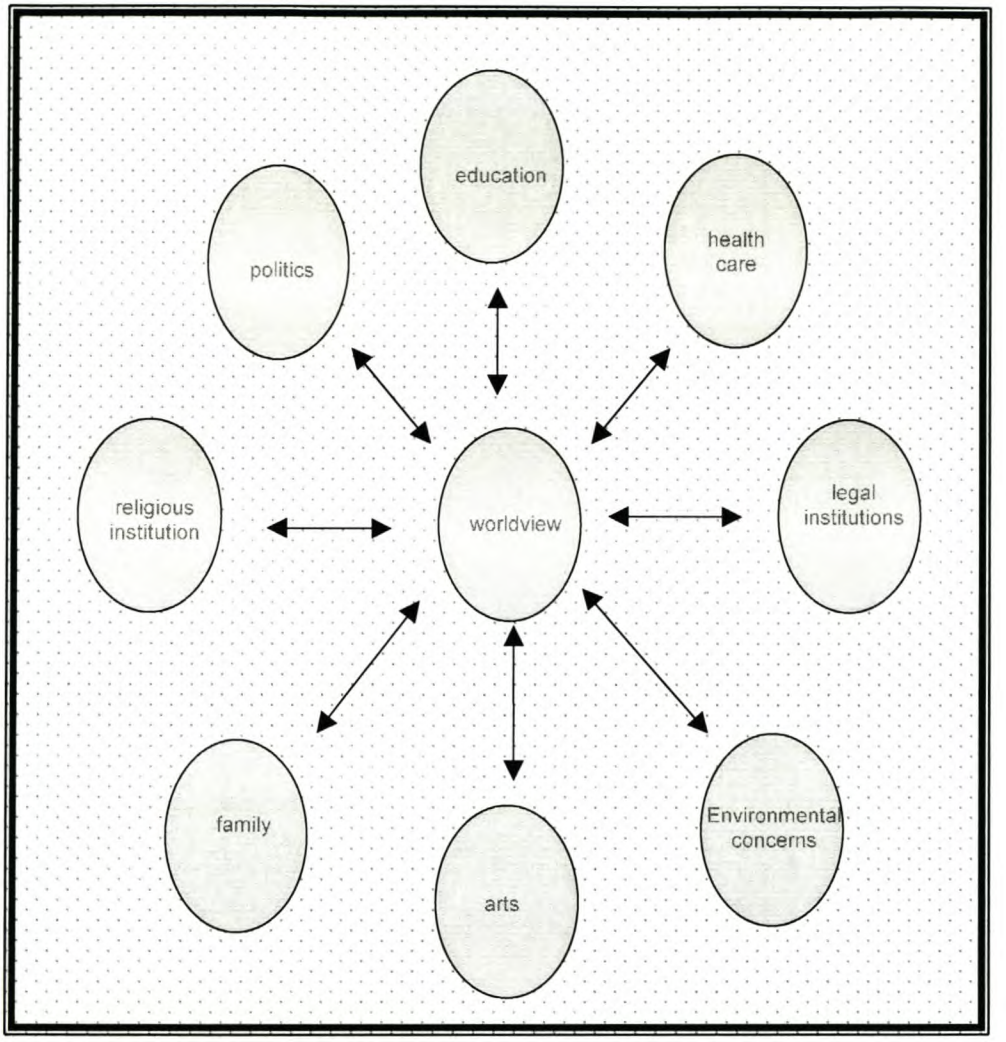
In the last 10 years the researcher completed a M.Sc. in Biomedical Sciences. The main subject of the research was ergonomics in health related fields. Concurrently an interest in quality improvement developed, culminating in the development of the practice accreditation programme for private physiotherapy practice.

The researcher's fundamental approach to life and life situations has a direct influence on her work performance. The researcher believes in Judeo-Christian values and supports the Jewish religion, traditional values and customs. The Jewish religion is a way of life and does not seek to dominate or destroy any other religious beliefs and customs. Each member is regarded as a loyal

member of the Jewish community, therefore no one member wants to do without the group support and approval. The group is firstly seen as the family and then as part of a greater family, namely the Jewish community. Therefore the research sees every individual as part of a group.

All humans are creations of God and have individual needs, namely personal, inter-personal, social and environmental needs. All these needs form part of a holistic being and all humans should be approached in a holistic way and their needs tended to in order to restore their holistic being. Walsh and Middleton (1984: 31) state the following: "Humans are creatures of vision. This does not simply mean that we have eyes. Animals have eyes. Rather, it means that we are creatures who live our lives in terms of our perspective, our vision of life. Humans make life choices, and they make them in terms of their way of looking at things. We are to set our eyes and our vision one way and not another. This gets to the heart of what a world view is. A world view is never merely a vision *of* life. It is always a vision *for* life as well. It is important to note, however, that world views (just like cultures) never belong to just one individual. World views are always shared, they are communal". In South Africa we deal with different cultures and world views. See Figure 2.1 for Walsh and Middleton's (1984: 32) interrelationship of world view and culture. The influence of the researcher's world view, as described above, formed the inductive part with the Activities of Living Model (Roper et al., 2000) and as the deductive part when formulating / compiling the evaluation instrument for the PhysioFocus practice accreditation programme. The aspects depicted in the researcher's world view correlates with those in the Activities of Living Model.

Figure 2.1. Interrelationship of a world view and culture (Walsh & Middleton, 1984)



The researcher further supports the assumption that education and training should be a life long learning process. All life experiences should be viewed and accepted as a learning process, this would include meeting and interacting with people from all walks of life, different cultures, religions, capabilities and professions. It should be incorporated in one's personal and professional growth, as well as living of life as a human being.

Personal health, including physiotherapy, is important to function satisfactorily in all aspects of daily living. Every health care practitioner is personally, and professionally-ethically accountable for the provision of quality physiotherapy treatment. This accountability is towards the self, patients, the profession and funders to provide quality care and quality management.

2.3.2. Activities of Living Model

The Activities of Living Model (ALM) (Roper et al., 2000: 14) was used as the conceptual framework. This model is briefly described in Chapter one in section 1.3.3. as part of the framework of the third order of the Botes Research Model (1998; 2000). See Chapter three (section 3.2.6.) for a complete description of this model. The accreditation programme will have to include all the aspects of the ALM.

2.4. LITERATURE RESEARCH

The literature research forms part of the conceptual framework. The quality of physiotherapy, as an integral part of health care can be monitored and improved by means of a structured programme. This programme should not only be regarded as a formal programme on the shelf, but as a process planned, implemented and formally and continuously evaluated. Several authors (Van der Horst & Mc Donald, 1997: 7; Killen, 1999: 1) have stated that a quality system should be judged from three different perspectives, namely, input (finances, resources and infrastructure), throughput (management, control and delivery of the service) and output (the end results and the satisfaction of all stakeholders). Currently in South Africa much is heard and read about the dissatisfaction with the health services and physiotherapy is a part of those health services. Although South Africa is regarded as a developing country it is a well known fact that the professional South African health care worker is a sought after commodity in the rest of the world. The health care professionals cannot afford to fall behind in the clinical performance of professional skills and knowledge. Patients and funders want value for money and therefore a quality service has to be supplied by the health professionals to avoid losing the patients and funders to other health professionals or alternative therapies.

The implementation of an accreditation programme, with an internal quality improvement programme, seems to be the obvious strategy to maintain quality physiotherapy, knowledge and skills.

The literature research is thus described according to:

- the foundations of professional physiotherapy practice in South Africa;
- the legislative framework for physiotherapy practice in South Africa;
- outcomes based education (OBE); and
- quality improvement including accreditation.

2.4.1. Foundations of Professional Physiotherapy Practice in South Africa.

Muller (1998: 17) describes a profession as "a specific career where work of an intellectual nature is performed. This career makes a public statement in respect of its uniqueness, the career specific training, education required, as well as the career specific values and norms that are pursued". This definition is in accordance with the Oxford Dictionary (Pearsall, 1998: 1480). Practitioners determine the unique characteristics and traditions of each individual profession. Professionalism implies that practitioners comply with the norms, traditions and expectations of the profession (Muller, 1998:17).

Muller (1998: 18-25) further describes a profession according to the 18 agreed international criteria. See table 2.1. for application of these in the physiotherapy profession.

Table 2.1. Foundations of South African Physiotherapy Applied to the International Criteria for a Profession (Muller, 1998: 18-25)

Criteria	Characteristics	Applied in Physiotherapy
One	Extensive specialised content with well developed technical skills.	Theory and practical training throughout the duration of the course.
Two	Utilisation of the theory of physical science, including disciplines related to the practice thereof.	Physiotherapy cannot be practised meaningfully without the utilisation of other sciences, such as physical, social, business and management sciences.
Three	Specialised preparation at a recognised educational institution over a specified period of time.	Preparation for physiotherapy at present in South Africa requires four years of integrated education and clinical training at a university. If successful a degree is awarded. Various post-graduate courses are available.
Four	Testing of professional competence before admission to fold of the profession	Formal clinical and theoretical evaluation takes place in respect of each subject prior to a physiotherapist being able to register as a professional.

Table 2.1. Foundations of South African Physiotherapy Applied to the International Criteria for a Profession (Muller, 1998: 18-25), cont.

Criteria	Characteristics	Applied in Physiotherapy
Five	A form of registration or licensure is required to practice professionally.	In order to practice professionally in South Africa, physiotherapists have to register with the HPCSA.
Six	Self-organisation, leading to the formation of a professional association and a self-governing body to control professional standards.	The SASP is the professional association for physiotherapists in South Africa. Standards are generated and controlled by the Professional Board (PB) of Physiotherapy.
Seven	Ethical control of professional conduct by the members of a profession.	Professional conduct of physiotherapists is controlled by the ethical rules set down by the PB. The PB possesses the power to discipline physiotherapists found guilty of improper or unethical conduct.
Eight	A service motive based on the needs of the client who requires professional assistance, regardless of the client's ability to pay for the service.	Much physiotherapy is performed in the community and in areas where clients are unable to pay for the services rendered.
Nine	A high degree of accountability for professional services towards the community as a whole (the public, clients, the employer and other members of the profession).	Registered physiotherapists are independent practitioners who are individually accountable for their acts and omissions.
Ten	Exclusiveness.	The physiotherapy profession sets the boundaries of its exclusiveness by setting specific training requirements, practice standards and registration.
Eleven	An acknowledged status in terms of legislation.	No physiotherapist is allowed to practice without the necessary registration and certificate of good standing from the HPCSA.
Twelve	A high social status and considerable power in society.	The members of a profession determine the social status and power of the profession. The ministry of health relies on the input from the profession in health care delivery. There is a relationship of trust between the profession and the community.
Thirteen	Performance of activities that are based on the understanding of what these activities involve. In this manner the effect of acts and omissions can be predicted.	Physiotherapy has not remained static. Transformation in the training programme is in progress to bring the training in line with the health policy of South Africa.
Fourteen	A sustained, critical analysis of activities and changes of practice, keeping the profession abreast of development and change.	Obsolete physiotherapy techniques and treatment methods are constantly replaced with better and more effective methods.
Fifteen	Members select the activities that are of material importance to the practice of the profession. These activities should be in realistic reach of the members.	The scope of practice and service delivery is determined by the members of the physiotherapy profession though the PB.
Sixteen	Individual members are allowed maximum discretion and initiative in practice, whilst remaining accountable for all actions.	Physiotherapists are independent practitioners and are professionally and ethically accountable for acts and omissions.
Seventeen	Members are obligated to provide the best practice in order to meet the needs of the client.	Physiotherapists are bound by the Hippocratic Oath to provide the best service to clients.
Eighteen	A sustained striving towards service excellence, because competence alone is not enough.	Standards of practice and accreditation address this striving for continuous and sustained excellence in physiotherapy service delivery.

Muller (1998:25-27) further describes professionalism as knowledge and skills, high standard of practice, leadership, self-regulation, professional commitment, social values and service-directedness. See Table 2.22. for the empirical indicators for the foundations of professional physiotherapy in South Africa (which is presented after the section on the literature research). Empirical indicators are the observed, practical criteria extracted from the literature. These indicators formed the basis for the evaluation of data collection and data analysis.

At present the curriculum of physiotherapy training is under revision by the PB. This is being done to bring physiotherapy training in line with the health policy of South Africa. The curriculum will conform to the regulations of SAQA. The SASP and the PB has formed a standards generating body consisting of all interested parties within the profession. This board has input from all the tertiary training institutions, the private practitioners group, community based physiotherapists as well as from specialist physiotherapists.

2.4.2. Legislative Framework

In the current cost-conscious and competitive environment of health care, physiotherapists are required to act appropriately in confronting varied and complex service delivery situations. This is only possible if the physiotherapist is empowered with the necessary knowledge and skills to formulate defensible judgements. The law permeates the practice of physiotherapy. It is imperative, therefore, for physiotherapists to have sufficient knowledge of the legal issues inherent in a given situation as an essential element of the decision making process. It is thus essential for physiotherapists to have a solid understanding of relevant legal matters to enable them to enhance the quality and effectiveness of the services they deliver. These legal issues should be incorporated in a logical and systematic fashion into the service delivery (Vestal, 1995: 320).

The effective handling of legal issues should be evidenced in the physiotherapy practice, continuous education on the understanding and the implementation of the relevant Acts should be presented in the format of outcomes for each practice. These outcomes should be in line with OBE. Effective transformation

of the integration of all education and training systems is ensured by a legislation framework. For this purpose the South African Qualification Authority (SAQA) Act No. 58 was passed in October 1995 (RSA, 1995; Phillips, 1997a: 1; Phillips, 1997b: 1).

The purpose of the SAQA Act is primarily aimed to: "... structure education and training in such a way that South Africa can become an international economic role-player" (Olivier, 1998: 1).

The South African Qualifications Authority (SAQA), was appointed in 1995 by the South African government to ensure effective transformation of education and training by means of a National Qualifications Framework (NQF) (SAQA, 1999a: 4). Qualification frameworks of various countries in the world display certain basic features, namely: the main purpose is to standardise qualifications; it should be described in unit standards; unit standards should be arranged at levels corresponding to the complexity of the competency being described (Malan, 1997: 4).

In South Africa, a statutory body, the Health Professions Council of South Africa (HPCSA), regulates physiotherapy practice and physiotherapy education, and sets standards for the profession. Therefore the legislative framework is described in terms of SAQA Act, No 58 of 1995 (RSA, 1995) and the NQF, and the HPCSA. Furthermore physiotherapists in private practice in South Africa are bound by the Medical, Dental and Supplementary Health Service Act, No 56 of 1974 (RSA, 1974) the Medical Schemes Act, No 131 of 1998 (RSA, 1998a), the Compensation for Occupational Injuries and Diseases Act, No 130 of 1993 (RSA, 1993a), the Occupational Health and Safety Act, No 85 of 1993 (RSA, 1993b), Health Act, No 63 of 1997 (RSA, 1978), Human Tissues Act, No 65 of 1983 (RSA, 1984), Pharmacy Act, No 53 of 1974 (RSA, 1975), the Skills Development Act, No 97 of 1998 (RSA, 1998b), the Basic Conditions of Employment Act, No 75 of 1997 (RSA, 1997a), the Higher Education Act, No 101 of 1997 (RSA, 1997b), as well as the Employment Equity Act, No 56 of 1998 (RSA, 1999). In the remainder of the text these Acts is referred to only by name.

2.4.2.1. SAQA and the NQF – Transformational Strategy of Education and Training.

All the processes required for the transformation of education and training are not yet completed. However, a number of structures, criteria and guidelines conveniently characterized as seven steps, are in place to facilitate implementation.

The **first step** taken to ensure effective transformation of education and training was by means of a National Qualifications Framework (NQF). The South African Qualifications Authority (SAQA) was commissioned to develop and maintain a National Qualifications Framework (NQF) that could serve all sectors of education and training equally well (Olivier, 1998: 4; Malan, 1997: 5; Mathews, 1997: 13).

One of the main functions of SAQA is to ensure that standards and qualifications on the NQF are internationally compatible. The South African Qualifications Authority (SAQA, 1999a) stated that the NQF with its commitment to outcomes-based education and training (OBET) is the means South Africa has chosen to bring about systemic change in the nature of the education and training system.

In terms of the SAQA Act, SAQA will have the following responsibilities:

- to facilitate the development and implementation of the NQF;
- to establish National Standards Bodies (NSBs) which will be responsible for the establishment of education and training standards and qualifications for a particular field/content cluster; and
- to register bodies responsible for the generation and recommendation of standards, the Standards Generating Bodies (SGBs) "and to audit achievements in terms of such standards and/or qualifications" (SAQA, 2000: 12). The bodies responsible for accrediting providers of education and training standards, are referred to as the Education and Training Qualifications Authority (ETQA) bodies (Human Science Research Council, 1995: 9; SAQA, 2000: 12).

The NQF provides the means to register all types of learning achievements within one of eight levels, providing for General, Further and Higher Education and Training bands (see table 2.2.).

Table 2.2. The Structure of the NQF (SAQA, 1999b)

NQF level	Band	Types of Qualifications and Certificates		Locations of Learning For Units and Qualifications		
8	Higher Education Training Band	Doctorates Further Research degrees		Tertiary/Research/ Professional institutions		
7		Higher Diplomas Professional Qualifications		Tertiary/Research/ Professional institutions		
6		First Degrees Higher Diplomas		Universities/Technicons/ Colleges/Private/Professional Institutions/Workplace/etc.		
5		Diplomas, Occupational Certificates		Universities/Technicons/ Colleges/Private/Professional Institutions/Workplace/etc.		
Further Education and Training Certificate						
4	Further Education And Training Band	School/College/Trade Certificates Mix of units from all		Formal high schools/ Private State schools	Technical/ Community/ Police/ Nursing/ private colleges	RDP and Labour Market schemes, Industry Training Boards, union workplace
3		School/College/Trade Certificates Mix of units from all				
2		School/College/Trade Certificates Mix of units from all				
General Education and Training Certificate						
1	General Education and Training Band	Std 7/Grade 9 (10 years)	ABET Level 4	Formal Schools (Urban/ Rural/ Farm/ Special	Occupation/ Work-based training/ RDP/ Labour Market schemes/ Upliftment programmes/ Community programmes	NGOs/ Churches/ Night schools/ ABET programmes/ Private providers/ Industry Training Boards/ unions/ workplace etc.
		Std 5/Grd 7 (8 years)	ABET Level 3			
		Std 3/Grd 5 (6 years)	ABET Level 2			
		Std 1/Grd 3	ABET Level1			
		1 year Reception				

The NQF's objectives as outlined in the SAQA Act are "to create an integrated national framework for learning achievement; facilitate access to, and mobility and progression within education, training and career paths; enhance the quality of education and training; accelerate the redress of past unfair discrimination in education, training and employment opportunities; and contribute to the full personal development of each learner, and the social and economic development of the nation at large" (SAQA, 1999a: 3; Olivier, 1998: 6).

The NQF is a structure/framework/system for integrating education and training and increased access to life-long learning (Clarke, 1997: 20-21; French, 1998).

According to Lewis (1999: 6) the framework would also address issues such as integration and relevance, credibility, coherence and flexibility, standards, access, articulation, and progression and portability. It is also the social construct and instrument through which access, quality, redress and development will most effectively be encouraged, as South Africa move towards becoming a truly learning society (SAQA, 1998a; SAQA, 1998b).

The benefits of the NQF are:

- A reliable approach to education and training, meeting specified quality standards and practices.
- Own standards will be developed and set up by industry, professional groups, such as the SASP and the formal education sector, such as the universities, with the accent on national qualifications.
- More training and nationally-based qualifications will be established in industries, such a physiotherapy private practice, that have not offered training in the past.
- Training/learning will be taking place in a variety of venues, formal and informal (i.e. from the work place to tertiary institutions).
- In specifying the standards of education and qualifications up front, the South African education and training industry will be better equipped to compete on the international market. Conversely, South African employers will be better able to establish the quality of foreign qualifications by comparing them to the standards of the NQF.
- Detailed and credible reporting of individual attainment will be available to industry, employers and providers (Philips, 1997a: 14).

The Education and Training Bands provide the basis for the integrated education and training framework for the recognition of already existing qualifications (Olivier, 1998: 7; Cosser, 1998a). Physiotherapy education is included in the Higher Education and Training Band (HETB) of the NQF.

Cosser (1998b: 8) noted that a qualification qualifies that a destination has been reached in terms of the quality (as "degree of excellence") of learning that has taken place throughout the period during which the learner has been

working towards the qualification. The South African Qualifications Authority Act (RSA, 1995) stated that "qualification" means the formal recognition of the achievement of the required number and range of credits, where the value of a "credit" is assigned to ten (10) notional hours of learning. "Notional hours of learning" means the learning time it would take an average learner to meet the defined outcomes. Contact time, time spent in structured learning in the workplace and individual learning is included (RSA, 1998a). The total credit value of a qualification for registration on the NQF is that the qualification must consist of not fewer than 120 credits (Gunthorp, 1998a).

The **second step** taken was the development of critical cross-field outcomes (essential outcomes). The development of critical cross-field outcomes (see table 2.3), also referred to as critical outcomes, was of the first tasks SAQA had to perform.

Table 2.3. Critical Cross-Field Outcomes (RSA, 1998a: 8)

Critical cross-field outcomes include but are not limited to:

a. identifying and solving problems in which responses display that responsible decisions using critical and creative thinking have been made;
b. working effectively with others as a member of a team, group, organisation, community;
c. organising and managing oneself and one's activities responsibly and effectively;
d. collecting, analysing, organising and critically evaluating information;
e. communicating effectively using visual, mathematical and/or language skills in the modes of oral and/or written persuasion;
f. using science and technology effectively and critically, showing responsibility towards the environment and health of others;
g. demonstrating an understanding of the world as a set of related systems by recognising that problem-solving contexts do no exist in isolation;
h. contributing to the full personal development of each learner and the social and economic development of the society at large, by making it the underlying intention of any programme of learning to make an individual aware of the importance of:
   i. reflecting on and exploring a variety of strategies to learn more effectively;
   ii. participating as responsible citizens in the life of local, national and global communities;
   iii. being culturally and aesthetically sensitive across a range of social contexts;
   iv. exploring education and career opportunities; and
   v. developing entrepreneurial opportunities.

According to SAQA (SAQA, 1997), all learning programmes should address the critical cross-field outcomes, since they are critical for the development of the capacity of lifelong learning.

The identification of fields of learning/content clusters was the **third step** taken. These fields of learning could differ from band to band. In terms of the SAQA Act (SAQA, 1995: 3), "field" denotes a particular area of learning used as an organising mechanism for the NQF. The NQF characterises and organises all learning into 12 fields (see table 2.4).

Table 2.4. NQF: 12 Organising Fields of Learning (SAQA, 1999a; RSA, 1998a)

Number	Fields of learning
01	Agriculture and Nature Conservation
02	Culture and Arts
03	Business, Commerce and Management Studies
04	Communication Studies and Languages
05	Education, Training and Development
06	Manufacturing, Engineering and Technology
07	Human and Social Studies
08	Law, Military Science and Security
09	Health Sciences and Social Services
10	Physical, Mathematical, Computer and Life Sciences
11	Services
12	Physical Planning and Construction

Physiotherapy education will be included in field/content cluster number 09 - Health Sciences and Social Services. Physiotherapy education should also be included in field 05 (Education, Training and Development). Every sub-field, i.e. Physiotherapy Science, will have its own SGB. These bodies should involve the providers, professional groups (e.g. the physiotherapy educators, the SASP and specialist physiotherapy groups), employees and employers. A SGB for physiotherapy education has been formed and is currently reviewing and restructuring the physiotherapy education and qualifications process. The NSB of a particular field/cluster, will receive inputs from all relevant SGBs and ensure coherence in the system by synthesising inputs and setting standards for the field (Gunthorp, 1998a). Therefore, as regulation commences from the top, innovation through the formulation of standards starts from the bottom and is profession specific driven.

The **fourth step** in the programme is identified as the statement of the purpose of the qualification according to the specific learning programme, assumptions of learning already in place, exit level outcomes and embedded knowledge. The purpose statement is explained by Gunthorp (1998a) as a concise

statement of the contextualised purpose of the qualification and the usage it intends to achieve. According to Phillips (1997b: 51) the purpose statement must relate directly to the title of the qualification and it must cover all the exit levels in order to satisfy the quality criteria in the formulation of the purpose statement. Quality criteria to address with formulation of the statement for learning assumptions must be applicable directly to the qualification, it must contain all the necessary information about "preferred entry requirements", they must really be appropriate, and if references to other qualifications/unit standards were made, titles and numbers must be accurate. Exit level outcomes must capture the planned combination of the learning outcomes for the programme, both specific and critical cross-field, that are required for competent and applied performance at the particular level. Quality criteria to address with formulation of exit level outcomes are: do the exit level outcomes relate directly to the purpose statement, is the wording for each exit level outcome clear, does it reflects the demonstration of the end-result of the outcome (verb, object/noun and conditions) and is each exit level outcome assessable. Embedded knowledge is referred to as "the knowledge base required for competent performance and achievement" (Phillips, 1997b: 52).

Step five of the transformation to outcome-based education and training, is the identification and/or formulation of specific outcomes for each exit level outcome. Each exit level outcome has a number of specific outcomes. The SAQA Act (RSA, 1995: 4; RSA, 1998a) describes specific outcomes as "contextually demonstrated knowledge, skills and attitudes that support one or more critical outcomes". According to Malan (1997: 20) the specific outcomes specify the specific learning outcomes that will have to be assessed whenever a learner's competence in a particular area of learning is to be determined. Quality criteria to address with formulation of the specific outcomes, require that the specific outcomes must relate directly to the exit level outcome and the purpose statement, the wording for each specific outcome must be clearly understood, the correct format must be correct - reflecting the demonstration of the end-result of the outcome (verb, object/noun and conditions), it must be sufficiently coherent to stand alone (avoid overlapping) and must be assessable.

The **sixth step** is the formulation of assessment criteria, range statements and performance indicators. Malan (1997: 21) and Phillips (1997a, 1997b) explain that each specific outcome has a number of assessment criteria which enable the assessor to judge the observable processes and products which serve as demonstrations of learners' achievements/ competence. Essential evidence of the learner having achieved a specific outcome, is stated by the assessment criteria. The assessment criteria must therefore set out clearly to evaluate the performance demonstrated by the learner. Quality criteria to address with formulation of the assessment criteria, are described by Phillips (1997b: 35-39, 53) as the following:

- assessment criteria should always be in the correct format of "noun-verb-condition";
- an evaluative statement and must be formulated in the present tense;
- related to the verb in the specific outcome (stipulate the level and quality of performance) and always begins with a noun; and
- that each assessment criterion must be met by evidence provided, each must reflect an essential component of performance (not simply a list of tasks) and must focus on only one activity.

The range statements describe the scope and level of complexity expected from learners at different stages. Range statements could also demarcate the context of the specific outcome or assessment criteria. According to Phillips (1997b: 39-40, 53) quality criteria to address with formulation of the range statement are:

- it must be written in the correct format –"critical categories (headings) and critical classes (sub-headings);
- should have more than one class under the critical category;
- it must give a clear indication of the parameters for the outcome;
- it must exclude examples ("examples should be under Notes");
- it must be essential to the specific outcome and assessment criteria; and
- must reflect current and emerging practice.

The purpose of a range statement is to minimise variations of interpretation. Performance indicators provide detailed information regarding the kind of demonstration indicating that a learner has acquired the necessary competence

(knowledge skills and attitudes) in a specific field of learning or at a specific level on the NQF (Malan, 1997: 21, 39). Quality criteria for performance indicators are that they must be indicative of the demonstration of competence.

Step seven entails the development of learning programmes/macro-curricula. The curriculum developers are responsible for the development of learning programmes/curricula. Programmes will be based on the specific outcomes and will reflect the critical outcomes and underpin the intentions identified by SAQA (Malan, 1997: 22).

Educators, as curriculum developers on micro-curriculum level will formulate the instructional programmes, according to identified and formulated learning outcomes. Continuous assessment of learner progress should be done according to the learning outcomes stipulated by educators of the instructional programme.

To ensure national and international credibility, assessment of the quality of the education and learning will be done by accredited bodies, namely the Education and Training Quality Assurance bodies (ETQAs) appointed by SAQA (Elliot, 1999; Republic of South Africa, 1998b; Olivier, 1998: 10). According to the Annual Report to Parliament (SAQA, 1998a), bodies currently carrying out ETQA functions will continue do so until the regulatory framework (ETQA Regulations) is operational. Co-ordination of quality assurance in higher education will be through a Higher Education Quality Committee (HEQC), a permanent committee of the Council of Higher Education (CHE). The CHE is responsible for quality assurance and promotion in higher education (Department of Education, 1997b). In terms of the Higher Education Act (RSA, 1997b) "higher education" means all learning programmes leading to qualifications higher than grade 12.

To change from the traditional methods of education and training in South Africa, transformation is a much needed and necessary progression. See Table 2.5. for a summary of the steps for effective transformation of education and training in South Africa.

Table 2.5. Steps for Effective Transformation of Education and Training in South Africa

Steps	Action
One	The formation of a National Qualifications Framework (NQF).
Two	The development of critical cross-field outcomes (essential outcomes).
Three	The identification of fields of learning/content clusters.
Four	The statement of purpose of the qualification according to the specific learning programme, assumptions of learning already in place, exit level outcomes and embedded knowledge.
Five	The transformation to outcome-based education and training.
Six	The formulation of assessment criteria, range statements and performance indicators.
Seven	The development of learning programmes/macro-curricula.

2.4.2.2. Medical, Dental and Supplementary Health Service Act.

Physiotherapy education is guided by legislation on a national and international level. In South Africa physiotherapy education and practice are regulated by a statuary body namely the Health Professions Council of South Africa (HPCSA). The regulations defining the scope of the physiotherapy profession are described in this section of the Act. Physiotherapists may offer their services in certain areas supplementary to medicine. As an independent practitioner, the physiotherapist has the authority to select and perform appropriate treatment according to the assessment of the condition. In the execution of all physiotherapy procedures the following framework is always implemented:

- Assessment of the underlying condition.
- Planning of the physiotherapy treatment.
- Implementation of the selected treatment.
- Evaluation and record keeping of the treatment and the progress.

The physiotherapist is a first contact practitioner and does not need a referral from a medical or dental practitioner or other health professionals (except in the case of patients treated under the Compensation of Occupational Injury and Diseases Act [COIDA]), although the most patients are referred by a medical or dental practitioner. The scope of physiotherapy (regulation 2301 of Act 56 of 1974) is summarised in table 2.6 and the procedures (regulation 2301 of Act 56 of 1974) in the scope of the physiotherapy practice on are summarised in table 2.7.

Table 2.6. Scope of Physiotherapy, Supplementary to Medicine

Field of Practice	Description
Orthopaedics	Fractures, dislocations, ligamentous and soft tissue lesions, joint deformations and diseases, infections of bone and their complications, amputations, tendon and muscle transplants
Neurology and neurosurgery	Intensive care and rehabilitation
Respiratory diseases and thoracic surgery	Inhalation therapy, intensive care and rehabilitation
Cardio-vascular diseases and surgery	Intensive care and rehabilitation
Obstetrics and gynaecology	Pre- and post operative surgical conditions, ante- and post natal instruction, pelvic infections and other gynaecological conditions
Intensive care units	Coronary care, organ transplantation, dialysis, respiratory failure, tetanus, extensive paralysis, unconsciousness, accident services and burns.
Rehabilitation	Maximum potential of patient in work and sport, including adaptation to permanent disabilities.
Sports medicine	Prophylaxis and treatment of all injuries and disabilities directly pertaining to sport.
Paediatrics	All related fields of medicine and surgery, including cerebral palsy, minimal brain dysfunction, developmental abnormalities, prevention of orthopaedic and postural deformities.
Geriatrics	All related fields of medicine and surgery, prophylaxis, rehabilitation and recreational activities.
Treatment of physical ailments of psychiatric patients	Relaxation therapy, maintenance or restoration of physical fitness, organisation of recreational games, sports and recreational activities.
Other surgical fields	General, plastic, urological, maxillo-fascial, opthalmological, ear, nose and throat, and other surgical conditions.
Other medical fields	Rheumatology, dermatology, ear, nose and throat fields, constitutional fields, Hanson's disease, cancer and other medical conditions.
Community care	Prophylactic physiotherapy services, district and domiciliary services, day hospital organisations, rehabilitation centres including schools, industries and others.

Table 2.7. Physiotherapy Procedures

Physiotherapy procedures	Description
Scientific movement techniques based on physiological principles	Massage, manipulation, electrotherapy, physical and supportive measures including advice and education of the patient for the prevention and treatment of injury, disease and disorders, facilitation of normal physiological processes and functional activities. Rehabilitation and restoration of function, including personal independence.
Examination	Physiotherapeutic examination according to the condition, including continuous assessment of patient's response to treatment and progress made.
Education	Prophylactic physiotherapy, prevention of joint and muscle strain, advice on lifting and handling of patients and heavy objects, prevention of recurrence of mechanical disorders, functional activities, rest positions and work postures, recreational and sports activities, care and handling of the aged and children, use of respirators, postural drainage at home or in hospital.
Passive movements	Relaxed passive movements, mobilisation techniques, manipulation, soft tissue stretching, traction.
Active movements	Facilitation of movement, inhibition of abnormal sensory input, assisted exercises, free exercises, resisted exercises, re-education of functional activities, use of gymnasia, sporting activities, group activities, breathing exercises, splints, supports and prostheses.
Various massage techniques	Including transverse frictions and connective tissue massage.
Electrotherapy	High frequency currents, low frequency currents, ultrasound and radiation.
Heat and cold	Application of heat and cold therapy.
Therapeutic use of water	Hydrotherapy
Mechanical aids	Splints, supports, braces, prostheses and other therapeutic and supportive devices including the selection of wheelchairs.

2.4.2.2.i. Acts or Omissions

There are rules specifying the acts or omissions in respect of which disciplinary steps may be taken by a professional board and the council in terms of chapter four of the Act No 56 of 1974. Autonomous regulation by the Professional Council also implies independent professional discipline when a physiotherapist is charged with professional misconduct. The advancement of health standards necessitates control by means of professional ethical standards and the monitoring of offence or omission within the scope of practice regulation. In the execution hereof, it is sometimes necessary to implement disciplinary measures against registered physiotherapists who constitute a threat to the welfare of the community and/or the integrity of the profession. The acts or omissions which may give rise to disciplinary steps taken against the registered physiotherapist are summarised in table 2.8.

Table 2.8. Acts or Omissions

Act or Omission	Description
Advertising	Must be done in a professional manner.
Canvassing and touting	No touting or canvassing for patients is allowed.
Iterant practice	Not allowed where another practitioner is established.
Naming of practices	Defensive names (i.e. Stellenbosch Physiotherapy Clinic as opposed to Joe Bloggs Physiotherapist) must be cleared by the professional board.
Information on professional stationary	Only professional information may appear on stationary.
Fees and commissions	No fees (commission) may be paid to any person for recommending a patient, nor may fees for treatment be shared with any person who did not take part in the treatment of the patient. No fees may be charged for services not personally rendered.
Partnership and juristic persons	No practicing in partnership is allowed with a person not registered in terms of the Act.
Supersession	Reasonable steps must be taken when taking over the treatment of a patient who is still under treatment by another practitioner.
Impeding a patient	No practitioner may stand in the way of a patient wanting to seek another professional opinion.
Professional reputation of colleagues	No unfounded allusions may be made about the professional reputation or skill of another person registered under the Act.
Professional secrecy	No information about a patient may be divulged without prior consent of the patient or guardian.
Certificates and reports	A certificate of illness must contain all the relevant and legible information about the practitioner, patient, disposition and type of exemption from work, period of validity, date of issue and examination.
Professional appointments	These must be in written form and may not affect the interest of the public adversely.
Secret remedies	These may not be used.
Consulting rooms	Consulting rooms may not be shared with any person not registered by the Act.
Council's statutory duties	No office bearer of the council may be prevented from performing their duties.
Exploitation	No person may be exploited in a manner detrimental to himself, the public or professional interest.
Financial interest in hospitals	A practitioner must display a conspicuous notice about his financial involvement in a hospital in his waiting room.
Covering	No professional not registered under the act may be employed, except in an emergency or with approval from the board.
Performance of professional acts	Professionals may only perform acts in which they are adequately trained and experienced.
Performance of professional acts by a physiotherapist	Physiotherapists must confine themselves to the treatment of the clinical diagnosis, must communicate with other health practitioners in the diagnosis and treatment of the patient and must refer a patient to the appropriate health practitioner when the patient's problems and needs are beyond the scope of physiotherapy.

2.4.2.3. The Health Act

The Health Act deals mainly with the duties of national, provincial and local authorities and collaboration amongst these authorities. It specifies which diseases are to be reported and the method in which they are reported and further deals with matters concerning the environment, contamination of

foodstuffs and water. The Act also includes health regulations for any institution where surgical and medical activities are undertaken. In table 2.9. the headings of the main regulations are summarised. Where applicable, physiotherapists must adhere to these.

Table 2.9. Health Act Regulation Headings

Regulations
Reportable diseases.
Transmittable diseases i.e. from animals to humans to other humans.
Conditions that hold health dangers for the population i.e. dangerous jobs, overpopulation, importation of dangerous cultures or micro-organisms.
Edible products from contaminated water.
Provision of water for human consumption and food provision.
Matters involving the protection of water collection, water purification, building of reservoirs, as well as pollution of water sources.
Dirt, night dirt removal or contamination of regained products.
Collaboration between local authorities and repayments of local managements.
Therapeutic or diagnostic products i.e. inoculation substances, tocsins, antidotes, instruments, equipment for the use of diagnosis and treatment.
Private hospitals, nursing homes, maternity homes, or other institutions where surgical and other medical activities are taking place.

2.4.2.4. The Pharmacy Act

It is a contravention of the Act to pretend to be a pharmacist or register as a pharmacist for profit. These acts are viewed in a serious light and are punishable by the law. Physiotherapists use certain medicines in the line of treatment, such as anti-inflammatory ointments in inflammatory conditions and certain medicines related to chest conditions (bronchodilatory and mucolytic mixtures). These are all schedule one, two and three type medicines and can be purchased without a prescription from a registered medical practitioner. In table 2.10. the functions specific to the pharmacy profession are summarised.

Table 2.10. Functions Specific to the Pharmacy Profession

Functions specific to the pharmacy profession
The preparation or mixing of medicine or medicinal matter for sale for medicinal purposes.
The mixing, sale or provision of a medicine on the prescription of a medical doctor or dentist, or a physical substance prescribed by a vetinary doctor.
The manufacturing or supervision over the manufacturing process.
Dispensing of certain medicine without a prescription from a medical doctor or dentist.
Labelling of dispensed medication.
Specific storage of all scheduled medication.

2.4.2.5. The Human Tissue Act

The nature of the profession compels physiotherapists to come into daily contact with human tissue. Some of this tissue for example blood and sputum require specific handling in the procurement and/or handling thereof. The regulations regarding the handling and appropriate treatment of these tissues apply to physiotherapists. The regulations applicable to physiotherapists are listed in table 2.11.

Table 2.11. The Human Tissue Act

Regulations
Obtaining, labelling and handling of bodily fluids and tissues.
Appropriate storage of collected bodily fluids and tissues for investigations.
Appropriate handling and handover of a deceased patient.
Appropriate handling of organ removal.
Specific regulations regarding blood (i.e. blood donations and receiving blood).

2.4.2.6. The Medical Schemes Act

The aim of the Act is the following:

- To consolidate the laws relating to registered medical schemes.
- To provide for the establishment of the Council for Medical Schemes as a juristic person.
- To provide for the appointment of the Registrar of Medical Schemes.
- To make provision for the registration and control of certain activities of medical schemes.
- To protect the interests of members of medical schemes.
- To provide for measures for the co-ordination of medical schemes.
- To provide for incidental matters.

Each physiotherapist in private practice in South Africa receives a practice code number from the Board of Health Care Funders on entering private physiotherapy practice. This practice code number has to be reflected on all accounts rendered to patients and medical aids. The medical aids also have to adhere to certain regulations regarding the handling of members and accounts submitted by members. In recent times some medical aids require pre-

authorisation for private physiotherapy treatment. Table 2.12. summarises aspects of the Medical Schemes Act.

Table 2.12. Aspects in the Medical Schemes Act

Regulations	Description
Limitation of benefits	The registered medical aid scheme may reduce the benefits to a member joining during a financial year pro rata.
Accounts levied by suppliers of services	A supplier of a service shall render an account to the member or dependant of a member of a registered medical aid scheme within 30 days of the rendering of a service. The account must contain the following information: 1. Surname and initials of the member. 2. Surname and initials of the patient. 3. Name of the scheme. 4. Membership number. 5. Practice code number. 6. Date of each service rendered. 7. Nature and cost of each service rendered. 8. A copy of a prescription for medicine if the scheme requires it. 9. Name and practice code number of the referring doctor. 10. In the case of an operation, the practice code number of the surgeon or dentist who performed the surgery as well as the names and practice code numbers of medical practitioners or dentists that assisted in such operations. 11. In respect of orthodontic treatment, a treatment plan,
Payment of benefits	A registered medical scheme shall 1. Pay to the member or the service provider, subject to the rules and regulations of the scheme any benefit within six weeks of the receipt of the claim. 2. Together with such payment the following minimum particulars: name of member and the membership number, name of the supplier of the service, final date of service which is covered by the payment as well as the total amount charged for the service and the total payment awarded.
Limitation on payments	1. Late submissions or resubmissions of accounts. 2. Accounts rendered by previous members. 3. If the scheme is of the opinion is erroneous or unacceptable for payment.
Appeals to the council	Any person who feels aggrieved and wishes to lodge an appeal can do so in the form of an affidavit no longer than three months after the decision to do so was made.
Investments	Assets equal to at least 20% of the total value of the scheme must be held in South Africa.

2.4.2.7. The Compensation for Occupational Injuries and Diseases Act

The Occupational Injuries and Diseases Act provides for compensation to employees for occupational injuries sustained, or diseases contracted during the course of their work. The philosophy of the Compensation Commissioner is that every effort should be made to restore an employee's health as soon as possible.

The Occupational Injuries and Diseases Act governs the reporting of all occupational diseases (including miners with diseases other than those that

affect the lungs). The Occupational Injuries and Diseases Act replaces the old Workman's Compensation Act which had a very limited schedule of compensable occupational diseases.

2.4.2.8. The Skills Development Act

The goal of the Skills Development Act is to:

- Provide an institutional framework to devise and implement national, sector and workplace strategies to develop and improve the skills of the South African workforce.
- To integrate those strategies within the NQF contemplated in the SAQA Act.
- To provide learnerships that lead to recognised occupational qualifications.
- To provide for financing of skills development by means of a levy-grant scheme and a National Skills Fund.
- To provide for and regulate employment services.

This Act is important in the basic training of physiotherapists and continuing education in order to maintain and increase post basic skills. At present the revision of the physiotherapy higher education learning programme will include different levels of physiotherapy competences. Different categories of physiotherapy training are envisaged. The Skills Development Act is summarised in table 2.13. below.

Table 2.13. The Skills Development Act

Purpose
Developing the skills of the South African workforce - to improve the quality of life of the workers, their prospects of work and their work mobility; - to improve productivity in the work place and competitiveness of employers; - to promote self-employment; and - to improve the delivery of social services.
Increasing the levels of investment in education and training in the labour market and improving the return on that investment.
Encouraging employers: - to use the workplace as an active learning environment; - to provide employees with the opportunities to acquire new skills; - to provide opportunities for new entrants to the labour market to work experience; and - to employ persons who find it difficult to be employed.
Encouraging workers to participate in learnership and other training programmes.
Improving the employment prospects of persons previously disadvantaged by unfair discrimination and to redress those disadvantages through training and education.
Ensuring the quality of education and training in and for the workplace.
Assisting: - work-seekers to find work; - retrenched workers to re-enter the labour market; and - employers to find qualified employees.
Providing and regulating employment services.

2.4.2.9. The Higher Education Act

The functions of the Higher Education Act are the following:

- To regulate higher education.
- To provide for the establishment, composition and functions of a Council on Higher Education.
- To provide for the establishment, governance and funding of public higher education institutions.
- To provide for the appointment of an independent assessor.
- To provide for the registration of private higher education institutions.
- To provide for quality assurance and quality promotion in higher education.
- To provide for transitional arrangements and the repeal of certain laws.

All physiotherapy training at present and in the future will have to comply with the regulations contained in the Act. The trend in other sectors in the health care environment is to move students and training programmes to the private

sector. This will also eventually become applicable to physiotherapy training programmes.

In addition to the Acts described in sections 2.4.2.1 to 2.4.2.9, physiotherapists in private practice in South Africa are also regulated by the following legislation:

2.4.2.10. Occupational Health and Safety Act

Health and safety at work is an issue that affects every employer and employee. It is also a complex subject and one that has been extensively regulated by the law. Physiotherapists working in the private sector are also regulated by the Occupational Health and Safety Act. This act is summarised in table 2.14 below.

Table 2.14. Summary of the Occupational Health and Safety Act

Act Requirement	Description
General duties of employers to their employees.	(1) Every employer shall provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risk to the health of his employees. (2) Without derogating from the generality of an employer's duties under subsection (1), the matters to which those duties refer include in particular (a) the provision and maintenance of systems of work, plant and machinery that, as far as is reasonably practicable, are safe and without risks to health; *(b)* taking such steps as may be reasonably practicable to eliminate or mitigate any hazard or potential hazard to the safety or health of employees, before resorting to personal protective equipment; (c) making arrangements for ensuring, as far as is reasonably practicable, the safety and absence of risks to health in connection with the production, processing, use, handling, storage or transport of articles or substances; *(d)* establishing, as far as is reasonably practicable, what hazards to the health or safety of persons are attached to any work which is performed, any article or substance which is produced, processed, used, handled, stored or transported and any plant or machinery which is used in his business, and he shall, as far as is reasonably practicable, further establish what precautionary measures should be taken with respect to such work, article, substance, plant or machinery in order to protect the health and safety of persons, and he shall provide the necessary means to apply such precautionary measures; *e)* **providing such information, instructions,** training and supervision as may be necessary to ensure, as far as is reasonably practicable, the health and safety at work of his employees; (f) as far as is reasonably practicable, not permitting any employee to do any work or to produce, process, use, handle, store or transport any article or substance or to operate any plant or machinery, unless the precautionary measures contemplated in paragraphs *(b)* and *(d)*, or any other precautionary measures which may be prescribed, have been taken; (g) taking all necessary measures to ensure that the requirements of this Act are complied with by every person in his employment or on premises under his control where plant or machinery is used; (h) enforcing such measures as may be necessary in the interest of health and safety; (i) ensuring that work is performed and that plant or machinery is used under the general supervision of a person trained to understand the hazards associated with it and who have the authority to ensure that precautionary measures taken by the employer are implemented; and causing all employees to be informed regarding the scope of their authority.
General duties of employers and self-employed persons to persons other than their employees.	(1) Every employer shall conduct his undertaking in such a manner as to ensure, as far as is reasonably practicable, that persons other than those in his employment who may be directly affected by his activities are not thereby exposed to hazards to their health or safety. (2) Every self-employed person shall conduct his undertaking in such a manner as to ensure, as far as is reasonably practicable, that he and other persons who may be directly affected by his activities are not thereby exposed to hazards to their health or safety.

Table 2.14. Summary of the Occupational Health and Safety Act, cont.

Act Requirement	Description
General duties of manufacturers and others regarding articles and substances for use at work	(1) Any person who designs, manufactures, imports, sells or supplies any article for use at work shall ensure, as far as is reasonably practicable, that the article is safe and without risks to health when properly used and that it complies with all prescribed requirements. (2) Any person who erects or installs any article for use at work on or in any premises shall ensure, as far as is reasonably practicable, that nothing about the manner in which it is erected or installed makes it unsafe or creates a risk to health when properly used. *(3)* Any person who manufactures, imports, sells or supplies any substance for use at work shall- *(a)* ensure, as far as is reasonably practicable, that the substance is safe and without risk to health when properly used; and *(b)* take such steps as may be necessary to ensure that information is available with regard to the use of the substance at work, the risks to health and safety associated with such substance, the conditions necessary to ensure that the substance will be safe and without risks to health when properly used and the procedures to be followed in the case of an accident involving such substance. (4) Where a person designs, manufactures, imports, sells or supplies an article or substance for or to another person and that other person undertakes in writing to take specified steps sufficient to ensure, as far as is reasonably practicable, that the article or substance will comply with all prescribed requirements and will be safe and without risks to health when properly used, the undertaking shall have the effect of relieving the first-mentioned person from the duty imposed upon him by this section to such an extent as may be reasonable having regard to the terms of the undertaking.
Duty not to interfere with or misuse things.	No person shall intentionally or recklessly interfere with, damage or misuse anything which is provided in the interest of health or safety.
Chief executive officer charged with certain duties.	(1) Every chief executive officer shall as far as is reasonably practicable ensure that the duties of his employer as contemplated in this Act, are properly discharged. (2) Without derogating from his responsibility or liability in terms of subsection (1), a chief executive officer may assign any duty contemplated in the said subsection, to any person under his control, which person shall act subject to the control and directions of the chief executive officer. (3) The provisions of subsection (1) shall not, subject to the provisions of section 37, relieve an employer of any responsibility or liability under this Act. (4) For the purpose of subsection (1), the head of department of any department of State shall be deemed to be the chief executive officer of that department

2.4.2.11. The Basic Conditions of Employment Act

The Basic Conditions of Employment Act aims to advance economic development and social justice by fulfilling the following objectives:

- To give effect to and regulate the right to fair labour practice by establishing and enforcing basic conditions of employment, and by regulating the variation of basic conditions of employment.
- To give effect to obligations incurred by the Republic of South Africa as a member state of the International Labour Organisation.

The Basic Conditions of Employment Act is summarised in table 2.15 below.

Table 2.15. Summary of the Basic Conditions of Employment Act

Labour requirement	Description
Regulation of working time	Ordinary hours of work, overtime, meal intervals, daily & weekly rest periods, work on Sundays, night work and public holidays, annual leave, sick leave, maternity leave, family responsibility leave.
Particulars of employment and remuneration	Written particulars of employment, informing employees of their rights, keeping records, payment of remuneration, information of remuneration, deductions ad other acts concerning remuneration, calculation of remuneration and wages.
Termination of employment	Notice of termination of employment, payment instead of notice, employees in accommodation provided by employers, payments on termination, severance pay, certificate of service.
Prohibition of employment of children and forced labour	Prohibition of employment of children, employment of children of 15 years or older, medical examinations, prohibitions, evidence of age, prohibition of forced labour.
Variation of basic conditions of employment	Variations by agreement, variations by the labour minister.

2.4.2.12. The Employment Equity Act

The purpose of the Employment Equity Act is to achieve equality in the work place by:

- Promoting equal opportunity and fair treatment in employment through the elimination of unfair discrimination.
- Implementing affirmative action measures to redress the disadvantages in employment experienced by designated groups, in order to ensure their equitable representation in all occupational categories and levels in the work force.

The Employment Equity Act is summarised in table 2.16. below.

Table 2.16. Summary of The Employment Equity Act

Act requirement	Description
Prohibition of unfair discrimination	• Elimination and prohibition of unfair discrimination • Medical testing • Psychological testing.
Affirmative action	• Identify and eliminate employment barriers • Design measures to further diversity in the work place • Make reasonable accommodation for people from designated groups to ensure equal opportunities • An employment equity plan.
Commission for employment equity	• A commission for employment equity was established by the labour ministry.
Monitoring, enforcement and legal proceedings	• Monitoring by employees and trade union representatives • Labour inspectors • Register of designated employers • Assessment of compliance • Powers of the labour court • Protection of employee rights
General provisions	• State contracts • Codes of good practice • Temporary employment services • Liability of employers • Obstruction • Undue influence • Fraud.

Table 2.22. at the end of the literature research gives a summary of the empirical indicators for legislation in physiotherapy practice.

2.4.3. Outcomes-Based Education (OBE)

Output, outcome or end-result are the dependent variables that reflect the achievements of an organisation (Hersey, Blanchard & Johnson 1996:150). When assessing effectiveness, Hersey et.al. (1996) speculate that as many as 90% of managers in organisations are measured on output alone. The effectiveness of managers is then often determined by net profits, as is the effectiveness by academics by the number of publications formalised and sport team managers by the win-loss record of the team under management.

The NQF (RSA, 1995: 2) describes an *outcome* as "that segment of a unit standard (an agreed national and international entity) which is a statement of the required learner capabilities that must be demonstrated.

Outcomes are specified by stated performances and assessment and range criteria". *Performance* is further described as "holistic or integrated demonstrations of mental, affective and manual activities. Performance also expresses particular values. Demonstration of performance for assessment requires completion of specified tasks, as well as explanation of the rationale for doing tasks in particular ways".

OBE is not a new approach. The concept has developed over the last few decades through the systematic application of educational ideas and has been part of the American educational practice since the 1950's. Several roots for OBE are found in the literature by King & Evans (1991: 73-74); Malan, (1997: 11-15) and Van der Horst & Mc Donald (1997: 8-12). The following is a summary of the history of OBE perspectives as described by the authors mentioned above:

- *Tyler's educational objectives*: In 1950 Tyler published a course syllabus "Basic Principles of Curriculum and Instruction". Tyler identified fundamental issues to consider when developing curricula and planning instruction such as educational purpose, content, organisation and evaluation. He indicated the importance of objectives for systematic planning and that a well-written objective should identify both the required learner performance after instruction, as well as the area of content/life in which this performance is to be applied.
- *Bloom's mastery learning*: Bloom's "Learning for Mastery Model" uses group instructional techniques to meet individual needs of learners with variations in both instruction and time.
- *Spady's outcomes*: Spady, who is largely responsible for the current popularity of OBE describes outcomes as high-quality, conclusive demonstrations of significant learning in context. According to Spady (1994: 18), demonstration (performance) is the key word.
- *Glaser's criterion-referenced learning*: Criterion-referenced measurement is described in 1963 by Glaser as a measurement that identifies a student's test performance on a continuum, ranging from "no proficiency" to "perfect performance". It is especially appropriate in OBE if linked to outcomes in providing feedback to assist in evaluating learning programmes.

The influence of the OBE roots is clear as the assessment of the OBE learning programme, and of the learner's competence, is done against specific criteria. Competence in the required outcome (learner performance) is gained through conclusive demonstrations of significant learning (in context) within the specific time frame for each learner's individual needs.

Spady (1996a: 3-4) emphasised the following purposes of an outcomes-based system:

- success for all learners and staff; and
- all learners are equipped with the knowledge, competence and qualities needed to be successful after they exit the educational system.

The literature reveals several perspectives on outcomes-based education. Most of these perspectives are derived from the work done by Spady (1996b: 3-4), the so-called "father" of outcomes-based education. These perspectives are described in Table 2.17.

Table 2.17. Perspectives on Outcomes-Based Education (OBE)

Author	Perspectives on outcomes-based education (OBE)
Brandt (1992/1993: 66)	• Learners *demonstrate the achievement of an outcome.* • Outcomes are performances, not content. • Outcomes only do not make education outcomes-based. • Listing items as outcomes requires evidence of achievement and demonstration of measurement of the outcome.
Killen (1999: 8)	• The emphasis is on *learner outcomes* rather than content or teaching strategies.
Malan (1997: 10)	• The definition of ***outcomes*** should form the basis of all educational activity
Olivier (1998: 24-25)	• The *outcomes always result in a product*, therefore the achievement of an outcome is: ❑ the result of a learning process; ❑ the result of series of performances; ❑ supported by embedded knowledge; ❑ supported by competencies; ❑ a clearly defined product; and ❑ always consists of an action verb, an object or a noun, and when necessary a qualifier/condition ⇒ action verb: signifies exactly the activity which is going to take place – a verb such as "demonstrate" is too vague, as outcomes must be demonstrated; ⇒ object/noun: it spells out what is going to be achieved; it names and limits the issue to be addressed (it is not a theme/topic); and ⇒ qualifier/condition: refers to the technology, methodology, scope, depth and level of complexity and parameters of achievement.

Table 2.17. Perspectives on Outcomes-Based Education (OBE), cont.

Author	Perspectives on outcomes-based education (OBE)
Spady (1996b: 4-6; 1996d: 2-6; Malan, 1997: 11-14; Olivier, 1998: 2)	• Four principles of OBE: ❑ *Clarity of focus*: All curriculum development, instructional delivery, assessment development is geared to what the learner has to demonstrate successfully at the "real" end. ❑ *Expanded opportunity*: Expanding the ways and number of times learners get a chance to learn and demonstrate acquired skills. ❑ *High expectations*: Dispensing with the bell curve standards, expectations and results. Learners must be able to do significant actions well at the end of training. ❑ *Design down*: from exit outcomes to subject outcomes to module outcomes. • Each outcome must be a *demonstration* judged against four criteria, namely: ❑ *high-quality* – at a minimum, it means thorough and complete; ❑ *culminating* – demonstration comes at a culminating point of the student's learning experiences, literally "at or after the end" – not "during the experience" as most people seem to assume; ❑ *significant learning* – the demonstration must show significant learning; significant content is essential. Content alone, cannot be an outcome because it is inherently inert – it must be manifested through a demonstration process; ❑ *contextual* – all demonstrations of learning occur in some context or performance setting.

Various authors (Killen, 1999: 2; Malan, 1997: 16-17; Spady, 1994: 19) suggest three forms/levels of demonstration that should concern educators, namely :

- *traditional outcomes* – most basic, a demonstration of specific learned competencies in a particular subject/topic. This resembles what educators refer to as lesson objectives;
- *transitional outcomes* – focus on the knowledge, skills and attitudes learners should have acquired and their ability to apply these in the outside world; and
- *transformational outcomes* – broadest, most complex, it focuses on life roles that require the highest degrees of ownership, integration, synthesis and functional application of prior learning because they must respond to the complexity of real-life performances and they could be expected to produce results.

OBE differs from traditional content- or competency-based learning. Content-based learning is aimed at the mastering of knowledge, with textbooks and educators as sources of information, while competency-based learning on identifying and listing of the generic competencies for a specific job. With OBE the learning process is learner driven and aimed at achieving outcomes (Olivier,

1998: 3). In an OBE system educators become facilitators of learning and the educators are provided with the means of installing in learners the ability to initiate change. Learners are encouraged to become independent thinkers and to ultimately manage themselves and their careers (Killen 1999: 12; Wallace, 1997: 5). The educator further acts as an experienced mentor who advises learners in learning and their approaches to life (Van der Horst & McDonald, 1997: 231-234). These and other effects of the paradigm shift from the traditional content-based learning system to the outcomes-based learning system are described in table 2.18.

Table 2.18. Paradigm Shift: Content-Based Learning System Versus Outcomes-Based Learning System (Olivier, 1998: 39)

Content based learning system	Outcomes-based learning system
• Rote learning • Syllabus is content driven and broken down into subjects • Textbook/worksheet-bound • Educator centered • Syllabus is rigid and non-negotiable • Emphasis on what teacher hopes to achieve • Curriculum development process not open to public	• Critical thinking, reasoning • Learning is process and outcome driven, connected to real-life situations • Learner and outcome-centered • Educator is facilitator and mentor • Learning programmes are seen as guides • Emphasis on outcomes – what learner achieves • Wider stakeholder involvement is encouraged

Spady's *design down curriculum development process* is based on the identification of specific areas of learning/roles to fulfil upon completion. From these *exit outcomes* are formulated. Effective *exit outcomes* should include a list of competencies for each exit outcome and correspond with the philosophy, vision and mission of the training institution. It should focus on real-life roles and responsibilities, provide direction to drive curriculum development and assessment. High-powered performance verbs are used to formulate an exit outcome. The exit outcomes of the learning programme can impact on all staff and learners, as well as on the instructional process (Malan, 1997: 11-14; Olivier, 1998: 2). Exit outcomes should also:

- describe the knowledge, skills, and attitudes that all learners are expected to demonstrate upon completion of the whole programme;
- provide the criteria for evaluation of successful teaching and learning; and
- identify the competencies required for successful completion.

Specific outcomes are formulated for each of the exit outcomes. These specific outcomes serve as the basis to establish competencies (knowledge, skills and attitudes/values) to be mastered in order to achieve the exit outcomes. Here the process of achieving the specific outcome is just as important as the final reaching of the exit outcome (Malan, 1997: 11-14; Olivier, 1998: 2).

Assessment in outcomes-based education and training is a continuous activity. The concepts, assessment and evaluation, have been used interchangeably over time, but they mean different processes. Evaluation enables an answer to the question "How good?" It requires that a judgement should be made about a learner's knowledge, behaviour/performance, and values/attitudes. Van der Horst and McDonald (1997: 170) stated that assessment is a strategy for measuring competence (knowledge, behaviour/performance and values/attitude). According to Spady (1994: 18) the key word to assessment is *demonstration*.

Traditional forms of assessment include summative assessment, formative assessment and norm-referenced assessment. Outcomes-based assessment consists of a series of activities, which take place in order to demonstrate competence in achieving outcomes. The assessment criteria are statements present in order to establish whether a specific outcome or certain aspect thereof has been achieved. The criteria for assessment are directly derived from the specific outcomes (Malan, 1997: 24-32; Olivier, 1998: 36-46; Van der Horst & McDonald, 1997: 168-180). To ensure fair, equitable judgement, the criteria used during the assessment process must be identified, formulated and made known to all candidates before assessment takes place.

In determining whether the demonstration/performance of a candidate was sufficient, the implications of Spady's four criteria (see Table 2.12.) are applied. The assessment must be summative (continuous monitor and feedback), performance-based (authentic – in the workplace / real-life environment), and criterion-referenced (assessment criteria).

Olivier (1998: 2) noted the curriculum design process in the outcomes-based learning programme begins with the intended learning achievements, i.e. the outcomes. Outcomes-based learning programmes serve as guides for this process. Spady (1996c: 7) stated that with OBE the instructional resources of an educational system should be focused and utilised in such a way that all students may learn more effectively. OBE, therefore, does not prescribe or advocate any particular curriculum or curriculum emphasis.

The message for educators in outcomes-based education is "commitment to continuous growth and improvement is critical to success" (Spady, 1996a: 5). Table 2.22 depicts the empirical indicators for OBE.

2.4.4. Quality Improvement and Accreditation in Health Care Systems

The New Oxford Dictionary for English (Pearsall, 1998: 12) defines accreditation as "(of an official body) give authority or sanction to (someone or something) when recognised standards have been met". The formulation of standards is the first step in the quality improvement process. Therefore for any health care facility to implement an accreditation programme, an internal quality improvement programme is an essential necessity. An accreditation process is thus described as a national supervising body for the evaluation of internal quality improvement processes. To achieve accredited status, a physiotherapy practice has to implement an internal quality improvement programme. No references to accreditation programmes in physiotherapy were found in the literature research.

Accreditation is a process of setting national standards and measuring the compliance thereof. National standards focusing on for example, physiotherapy, are formulated and implemented by the profession and services at large (Muller, 1996a: 71).

The structure of national organisational standards include:

- The mission and scope of the service;
- Management and direction;
- Personnel structure and development;
- Operational policies and procedures;
- Facilities and equipment; and
- Quality management (1996a: 71).

The mission statement serves as the baseline against which all other standards within the health care service are assessed. Simultaneously the mission statement provides the parameters against which the standards relating to the management system, staff, equipment and operational activities, including the systems which departments utilise to monitor the quality of their own work. The assessment takes into account the capacity of a particular section of the health service to meet the standards within the goals and objectives of that section of the health service under review. Standards aim to improve the quality of the health service. The standards should ensure that clinical, management and supporting systems are organised and interlinked in a co-ordinated manner that will facilitate and optimise patient care and the efficient use of resources (Muller, 1996a: 71).

New values and economic restraints are two critical elements responsible for social change in health care systems. High quality is a prevalent value of this new era of health care and with the world wide economic recession, cost effectiveness has become a necessity (Abruzzese, 1992: 293).

"Value, which is the relationship between quality and cost, has become the new objective of health care. In a resource driven environment, the challenge is to keep quality up and costs down. Institutions that achieve cost-effective quality will have the competitive edge" (Abruzzese, 1992: 293).

There are several factors that influence the quality of health care being rendered, such as, the specialised knowledge and skills of management regarding quality improvement in the health care organisation. The patient has

certain expectations and rights regarding the quality of the health care organisation and the service being rendered, especially when the cost of health care is taken into consideration.

The word "quality " has become a general concept in health care and other business institutions. Terminology such as quality assurance has been replaced by total quality management, quality assessment, and also quality environment. It is important to realise that quality assurance is not unique to health care. Concepts regarding the provision of quality in products and services, have been in existence in the industry and manufacturing business for years (Marelli, 1993: 194).

What is quality then? The Oxford Dictionary (Pearsall, 1998: 1515) defines quality as "a degree of excellence, a distinctive attribute or characteristic possessed by someone or something". One of the distinctions of a profession is the continuous strive towards excellence. Quality is thus the characteristic of excellence as implemented in practice. The principles of quality improvement include the validity and reliability of the programme and the commitment of all who are involved, as well as the quality improvement programme being a continuous process. The quality improvement process is the formulating of standards, evaluating of actions and the implementation of remedial actions. Quality thus refers to the care that is expected, and the assurance that it will be delivered (Muller, 1998: 45).

What are the characteristics of excellence? Muller (1998: 238) describes the general characteristics of excellence in the health care environment as:

* *applicability* - to make the right decision at the right time;
* *acceptability* - to be legal, acceptable and cultural;
* *safety* - to maintain a therapeutic environment (physical, mental, and spiritual) with appropriate risk management;
* *equality* - money, race, sex and social status will not play a role;
* *accessibility* -to provide health care services, facilities, equipment and expertise of personnel;

* *effectiveness* - to be assessed in the clinical results and resource utilisation;
* *professional knowledge and competence* - should be according to the needs and demands that are set; and
* *satisfaction* -demonstrated by the patient, family, doctor, nurses, management, the physiotherapist and other team members.

2.4.4.1. Principles of Quality Improvement

When the literature about quality is explored, the names of Deming, Juran and Crosby are mentioned frequently. The work of these quality theorists is described by several authors (Hurwitz, 1997; Devargas, 1995; Hadgraft & Holecek, 1994; Soarez, 1992; University of Maryland, 1991; Yoder-Wise, 1999; Latzko & Saunder 1995:34; Sallis, 1993; Rinehart, 1993; Bonstingl 1992:72-82; Deming, 1986; 24-88; Paine, Turner & Pryke: 1992; Walton 1989; Green, 1994:16; Oakland 1989:288; Pike & Barnes:1996:70; West-Burnham: 1992:19, Crosby, 1984: 97-120). Dale (1994: 20) states that in broad terms Crosby focused on company-wide motivation, Deming on statistical process control and Juran focused mostly on project management. There is also extensive literature on the adaptation of Deming's philosophy in the field of education. The principles of these quality theorists are summarised in table 2.19.

Table 2.19. Principles of Three Quality Theorists

W. Edwards Deming	Philip B. Crosby	Joseph M. Juran
• ***System of profound knowledge*** ❖ Appreciation for a system ❖ Understanding of the theory of variation ❑ Theory of knowledge ❑ psychology • ***Deming's 14 Points of Quality Management*** ❑ constancy of purpose (for improvement of product) ❑ adopt the new philosophy ❑ cease dependence on inspection to achieve quality ❑ end the practice of awarding business on the basis of price tag ❑ improve constantly and forever ❑ institute training ❑ institute supervision ❑ drive out fear ❑ break down barriers between departments ❑ eliminate slogans ❑ eliminate work standards that prescribe numerical quotas ❑ remove barriers ❑ institute a vigorous programme of education ❑ put everybody in the company to work in teams • ***Seven sins of management*** ❑ Lack of consistency of purpose ❑ Short-term thinking ❑ Evaluation of performance, merit rating or annual review ❑ Running an organization on visible figures alone ❑ Staff mobility ❑ Excessive medical costs ❑ Litigation	• ***Four Absolutes of Quality*** ❑ Conformance to requirements ❑ Prevention – eliminate errors ❑ Zero defects – do it right the first time ❑ Price of nonconformance – tool for effectiveness and efficiency • ***Prevention Process*** – anticipate errors that could occur • ***Quality Vaccine*** ❑ Determination ❑ Education ❑ Implementation • ***Six C's*** ❑ Comprehension ❑ Commitment ❑ Competence ❑ Communication ❑ Correction ❑ Continuance • Crosby's 14 steps for quality improvement ❑ Management commitment ❑ Quality improvement team ❑ Measurement ❑ Cost of quality ❑ Quality awareness ❑ Corrective action ❑ Zero defect planning ❑ Employee education ❑ Zero defect day ❑ Goal setting ❑ Error-cause removal ❑ Recognition ❑ Quality councils ❑ Do it over again	• ***Spiral of Progress in Quality*** – series specialised activities carried out by specialised departments • ***Breakthrough Sequence*** – dynamic decisive movement to higher performance levels • ***Project-by-Project Approach*** - the heart of Juran's philosophy • ***Juran Trilogy*** ❑ quality planning ❑ quality control ❑ quality improvement • ***Principle of the Vital Few and Trivial Many*** – small number of poor quality and the useful many good qualities.

Quality improvement is defined as a programme of systematic evaluation to ensure excellence in health care. The two main components in the programme entail:

i) the assurance of measuring and the determination of compliance to these standards; and
ii) the implementation of changes based on the information acquired through measurement so as to improve care (Affara & Styles, 1991: 17).

The Duke University Hospital had already in 1983 summarised the process of quality improvement, as the methods through which groups of health care workers and the employers ensure the public that services rendered in the organisation is on par with standards from other institutions, for similar services (Duke University Hospital, 1983: X1).

According to Douglass & Bevis (1983: 281) quality care is based on safety for the patient, staff and others; advancement of technology and therapeutic procedures; the economical effectiveness, and acceptance of ethical and moral issues.

Several principles for quality improvement have been described (see Table 2.19). The principles of quality improvement in the health care organisation are described by Gillies (1989: 395) and Muller (1995: 93) as the following:

* Quality improvement requires a multi-professional team approach.
* Aims must be goal orientated to ensure a total quality improvement programme.
* The utilisation of resources for quality improvement activities must be applicable.
* The focus must be on the critical factors in health care to ensure optimal resource utilisation.
* The basis for quality improvement is the accurate assessment of patient care and requires complete and accurate documentation.
* Evaluation of practice performance will not necessarily improve the practice, as remedial actions are necessary.

* Group pressure after evaluation can enforce positive pressure towards anticipated changes.
* Organisational changes regarding quality improvement need management support.
* The effectiveness of quality improvement necessitates that top management be involved, to ensure the necessary feedback and remedial actions.

Quality improvement in a health care organisation is a systematic process, with commitment by all individuals and the necessary support from staff development and management. Quality improvement is thus one of the responsibilities of management (Van der Merwe, 1994: 78).

Modern quality management is insight into the process of production. The quality management that was first implemented in the industry, included concepts such as the processes of production, insight into the meaning of quality regarding success and failure, as well as the methodology in the planning and improvement of quality. The function of each individual is to cooperate to enhance value to the product and to communicate this to the consumer. The employee is seen as the consumer, manufacturer, and supplier (Koch & Fairly, 1993: 2).

Health care has adopted a similar model for health management. To enhance the quality of current health care services, managers should implement quality assessment and improvement regarding utilisation management, risk management, safety management, and infection control methods, so that the "product" can be improved (Koch & Fairly, 1993: 2).

In the current health care environment for an organisation to have a competitive edge, it necessitates quality management. It is a discipline concerned with doing the right things right, the first time. It is a systematic method to ensure that things go according to plan. "Quality management means that services are planned, implemented, and evaluated to ensure high-quality services for the consumer" (Abbruzzese, 1992: 295). The service is thus goal orientated,

appropriate standards are set with both monitoring and remediating processes in place.

There are three interrelated components of quality management, that is, quality awareness, quality appraisal, and quality improvement. Through the development of a value system quality awareness is fostered. The value system is found in the written standards of the organisation and is composed of the steps of commitment to quality, preparation for development (the education of the staff), the development of standards, standardising the standards by means of a committee and formalising this process. The foundation of quality appraisal is found in quality awareness (Van der Merwe, 1998: 20- 27; Abbruzzese, 1992: 295).

Physiotherapists as part of the multi-professional team of health care in institutions, can gain through the implementation of a quality management process. The physiotherapist should display the art of physiotherapy, communication, empathy, and interpersonal skills, as well as the "science" of technical skills in her/his practise (Koch & Fairly, 1993: 8).

Documentation in the health care patient records is of vital importance for quality management. Accurate documentation protects the health care worker and the organisation against litigation. The risk component is underwritten by the documentation (Koch & Fairly, 1993: 8).

Quality appraisal provides the data needed for quality improvement. To obtain the data, monitoring and evaluating activities should be in place. These activities will include performance review, customer satisfaction analysis, and research. Quality appraisal confirms the achievement of results, staff compliance with standards, and the satisfaction of both internal and external customers (Abbruzzese, 1992: 295).

Essentially we may track down performance in four main areas. One or more will fit any job classification: quantity, quality, timeliness and cost (Lovelock, 1996: 506; Brown, 1985: 120). Quantity is one of the most common methods of

measuring performance. In one way or another, the total number of hours worked or the number of specific jobs done are added up. Quality, on the other hand, is one of the most important areas for which standards apply. Measurement from the quality standpoint includes at least two factors: errors and appearance. Errors can include monitoring defects, misfile of documents and safety records and customer/ patient complaints. Appearance deals with items other than rejects or specific errors and is more subjective in judgement. It will include aspects such as neatness, a person's manner in answering a phone, or an explanation to a dissatisfied customer.

Timeliness encompasses such responsibilities as meeting deadlines, on-time actions and absenteeism. Timeliness, also, can involve new and workable approaches. The most creative idea needs the right time for its introduction.

Cost is related to the three m's in management: men, money and materials. Is the person able to perform, manages his/her time effectively and can he/she live within the budget?

Crosby (1984: 184) states that quality appraisal (the testing, the planning, the inspection, and all other appraisal activities) is a waste of time if it does not lead to the prevention of the recurrence of a problem. Quality improvement means that all the staff in an organisation is trying every day to do their jobs better, and not just keeping to the minimum standard to satisfy quality assurance activities. The need for ongoing quality awareness is thus reinforced through quality improvement.

Quality improvement that is included in quality management, builds on the strengths of the assessment of quality assurance and remediates the faulty actions. In retrospect The Joint Commission for the Accreditation of Healthcare Organisations (JCAHO: 1998) declare, that quality assurance is an "unfortunate semantic selection" because quality can never be assured, but can only be improved (O'Leary, 1991: 4).

A distinction should be made between the actions of quality assurance and quality improvement. Quality assurance and quality improvement are not synonymous but complement and enhance each other. Quality assurance is inspection orientated whereas quality improvement is geared towards prevention. Quality assurance is reactive against the proactive actions of quality improvement. Quality assurance has a narrow focus, with the responsibility of a few, with correction of special clauses and authoritarian problem solving. The correction of common causes is cross functional and responsibility and problem solving of all under guidance of an active leader in quality improvement (Koch & Fairly, 1993: 18; Vestal 1995: 204).

Although management is ultimately responsible for the health care in the organisation, each individual is responsible for improving care. The responsibility for health care quality improvement is delegated down from the management structure to the health care administrators. The commitment and degree of involvement by the health care worker is directly related to participation and ownership in the process. The programme must be tailored to facility, based on size, available resources, patient expectations, as well as availability of staff and time allocation (Muller, 1998: 253; Koch & Fairly, 1993: 19).

It is also imperative for a quality improvement programme to include infection control aspects. No quality improvement programme in the health care environment is complete without being applied to infection control practices. Healthcare delivery costs associated with nosocomial infections continue to grow. Escalating bacterial resistance within hospitals increasingly causes problems. A lot of factors are the causes of hospitals filled with a growing population of critically ill and immunologically impaired patients (Association for Professionals in Infection Control, 2000).

It has been clearly shown that in many first world countries, where effective infection control programmes are utilised, the incidence of nosocomial infections and problems associated with resistant pathogens are low. An effective

infection control programme plays a vital role in reducing the costs to both the patient and the health care organisation (Pearse, 1997: 5).

To assess the cost-effectiveness of an infection control programme it is necessary to determine the cost of a nosocomial infection. Factors that contribute to the cost of a nosocomial infection are additional days of hospitilisation, prolonged use of antibiotics and other equipment, the cost, in time and money, of physiotherapy, and nursing staff looking after patients who have acquired the nosocomial infection. The consequences to the patient are severe, and can include loss of income, leave, employment, pain and suffering and possible death (Pearse, 1997: 6).

Patient and family education also forms an important aspect of quality management (Koch & Fairly, 1993: 28). Education on health related matters is one way of keeping medical costs down and preventing admission to health care facilities.

Unfortunately, the health care market in South Africa is of such a nature that the demand for health care services is higher than that which can be supplied. A specific health care unit can be marketed based on for example patient and health care worker satisfaction (Van der Merwe, 1994: 94).

Initially, it is costly to implement a formal quality improvement programme but it has been proven over again that where a quality improvement programme is implemented, the functioning of the health care workers are more cost effective. The quality improvement process should thus be based on the principles of the setting of standards, the evaluation of work performance and the implementation of remedial actions. The process of quality improvement requires a team effort with committed personnel to the concept of quality. Commitment requires that health care workers are active participants and continually educated regarding the process of quality improvement (Van der Merwe, 1994: 93). The personnel in a physiotherapy practice have a choice whether to improve the care in the practice in a proactive way or to implement crisis management. A few of the motives for formal quality improvement in a

private physiotherapy practice are professional liability, the quest for excellence, the internal desire for positioning, a competitive market, and financial considerations (Muller, 1996a: 225). The physiotherapy practice manager and every health care worker are responsible and accountable for quality health care because the South African public are also more aware of their rights, which is evidenced in the increase of court cases in the country. It is a fact that every health care worker has an internal desire to compare his/ her work performance with that of the others. Think of how we compare one health care organisation with another.

2.4.4.2. Components of a Quality Improvement Programme (QIP)

According to Muller (1998: 253) and Swansburg (1995: 497- 498) the components of a quality improvement programme should include the following:

- Establish a QIP committee.
- Compile clear and concise written statements of intent, philosophy, and objectives.
- Provide standards or indicators for measuring the quality of care.
- Ensure that policies and procedures for using such standards for gathering data are in place. These policies define the organisational structure for the quality improvement programme.
- Analyse and report the data gathered, with isolation of problems.
- Utilise the results to prioritise the problems.
- Monitor clinical and managerial performance and give continuous feedback to ensure problems stay solved.
- Evaluate the quality improvement system.

The first element of a planned QIP is the development of clear and concise statements of intent, philosophy and objectives. This needs a group effort and health care workers should not only state the organisational mission and purpose, but should include aspects like social, cultural, economic or religious aspects. Each role player has a different expectation of quality: management judge it by cost-saving and clinical output, patients by the swiftness of the

resolution of their problem. The expectations of the health practitioner are influenced by their world view, together with values acquired during their training at the educational institution. To maintain quality health care continuous education of staff should be incorporated in the philosophy (Muller, 1998: 241). The quality philosophy embraces the challenge to learn and grow. Given the history of health care delivery in South Africa, the proponents of quality will realise that persistence and perseverance will be necessary to spread its philosophy.

2.4.4.3. Standards

The formulation of standards is one of the first steps in quality improvement. It is important that health care workers are responsible for the formulation of the standards, which are congruent with their and their team concepts of quality health care. Thus, these standards evolve from present practice, and the responsibility assumed, enhances the professionals experience of sense and meaning in their roles (Van der Merwe, 1994: iv).

The International Council for Nurses (ICN) define a standard as "the desirable and achievable level of performance against which actual practice is compared" (ICN, 1989: 24). Whereas standards represent an agreed upon level of performance, criteria are specific measurable statements reflecting the intent of the standard. In the ICN glossary, a criterion is defined as 'an objective, measurable, relevant, and flexible indicator of quality care related to performance, behaviour, circumstance or clinical status'. Mason (1994: 1) defines a standard as a valid definition of the quality of health care. To guarantee quality, each standard must be valid. A number of criteria usually relate to a standard (ICN, 1989: 5; Mason, 1994: 1-5).

There are three types of standards in general use. These originated from the work of Donabedian (1986: 99-106) and Mason (1994: 1) who suggested that health care can be measured in three ways: as structure, process, and outcome.

* Structure standards will include the characteristics such as facilities, equipment, and resources of the organisational setting in which the health care practice takes place, that is human, environmental, organisational and physical resources.
* Process standards include all the actual activities and interactions between health care providers and the recipients of health care (or between programmes and students), for example, activities, interventions, and the sequence of care giving (or educational) events.
* Outcome or Product standards are the end result, comprising a measurable change from the delivery of health care activities, that is, physical and mental health status, social and physical function; health attitudes, knowledge and behaviour, utilisation of professional resources and the patients' perception of care.

Affara & Styles (1991: 62) present the following view: "Structure, process, and outcome standards may be developed for health care practice, the health care service, and health care education. Standards for the health care practice may relate to the professional's performance or behaviour in the defined dimensions of the professional role, specifically the education, research, accountability, ethical conduct, resource utilisation and peer review functions of the professional health care worker. Examples here are the making of a health care diagnosis, determination and implementation of a plan of care, and evaluating the effectiveness of that care". Other examples of standards may relate to expectations regarding: the philosophy and objectives of the health care organisation; organisation and management; staffing and supervision; patient care; policies and protocols; staff development; and quality improvement (Affara & Styles, 1991: 62; Mason, 1994: 1-5; Muller, 1999: 242).

According to Muller (1996a: 69) a standard is a written description of the devised level of performance. This description should contain the characteristics associated with excellence for the measurement and evaluation of the actual performance or service delivery. Muller (1996a: 69) further supports Mason (1994) and Donabedian (1986: 99-106) on the issue of three types of standards (structure, process and outcome), where the structure standards refer to the

support system required for the delivery of health services. These apply to the utilisation of human, financial and physical resources. Process standards specify how specific actions should be performed and it therefore applies to the activities of constituting care, services rendered or management. Outcome standards relate to the objectives that were achieved and address both the clinical and non clinical actions.

Coetzee and Muller (1995: 18) further define a standard as a descriptive statement to evaluate the expected level of work. Astrop, Van der Merwe and Muller (1996: 3) explain further that standards are classified according to structure, process and outcome structure, including all structured elements needed to implement a standard safely. The scientific manner in which a physiotherapist performs an action is reflected in the process, whilst the outcome reflects the intention in both the structure and process standards.
Quality improvement is a process of continuous standard formulation, continuous evaluation and the implementation of remedial or corrective actions. Quality improvement in a health care organisation is a systematic process, with commitment from all health care workers to do the right thing right the first time. It is a team effort with a top down approach from management (Crosby, 1984: 184).

Outcome standards define the expected change in a situation, as well as the extent of the satisfaction of clients with the service provided. Outcome standards highlight the absence of negative outcomes, as well as the presence of positive outcomes (Mason, 1994: 3). In table 2.20. the steps in standard formulation according to Mason (1994: 5-59) are summarised.

Table 2.20. Steps in Standard Formulation (Mason, 1994: 5-59)

Steps	Process standards and actions	Outcome standards and actions	Content/structure standards and action
1	Select a procedure	Identify the procedure	Define the practice activities
2	List the goals of the procedure	Identify the goals of the procedure	Identify the goals of data collection
3	Identify the steps in the procedure essential in achieving the goals	Identify expected positive outcomes	Identify items of data collection
4	List pertinent observations. Specify when each of the steps should occur	Identify preventable negative outcomes	Combine the standards in a logical order
5	Observe the procedure	Specify expected timeframe for each outcome	Establish the validity of the standards
6	Combine the steps in logical order	Clarify the description of expected outcomes	
7	Eliminate suggestions and rationale from the standards written	Combine the outcome standards in a logical order	
8	Establish the validity of the process standards	Establish the validity of the outcome standards	

2.4.4.4. Tools for Collecting Quality Improvement Data

One of the elements of a quality improvement programme (QIP) is to develop policies and procedures for using standards or indicators for data gathering when measuring the quality of care. This will define the organisational structure for the QIP and will prescribe the tools for data gathering (Swansburg, 1995: 498). Standards are not evaluation instruments. Tools or instruments are decided upon to gather evidence that the standards have been met. In the event of a quality improvement committee deciding that other tools must be developed, these tools must determine reliability and at least content validity. An audit tool is a data collection tool. There are three basic forms of audits, namely structure audit, process audit and outcome audits. Other forms of collecting quality improvement data include direct observation, self-evaluation, interviews, peer group evaluation, incident monitoring and patient satisfaction. In this research the structure audit method will be used to collect the research data. In table 2.21. the tools for collecting audit quality improvement data are summarised.

Table 2.21. Tools for Collecting Audit Quality Improvement Data (Swansburg, 1995: 504)

Data collecting tool	Description
Structure audit	•The focus is on the setting in which the care takes place. •This includes physical facilities, equipment, organisation, policies, procedures and medical records, staff knowledge and expertise.
Process audit	• These are task orientated. • Quality is measured after a cycle of care has been completed. • Independent physiotherapy functions based on the physiotherapy process are measured. • In this model a medical record is randomly selected, evaluated and feedback given.
Outcome audit	• Physiotherapy performance is measured in terms of the patient outcome criteria. • A determination is made whether outcomes have been met. If not, deficiencies are corrected and followed up.

2.4.4.5. Quality Improvement Models

The following quality improvement models are described:

* The Continuous Quality Improvement (CQI) Model.
* The World Health Organisation (WHO) Model.
* The Australian Physiotherapy Association Model for Quality Improvement.

2.4.4.5.i. The Continuous Quality Improvement Model

Continuous improvement has been described by Bowring-Carr and West-Burnham (1994: 14) as the driving force of the quality movement. This total quality management concept is sometimes referred to by the Japanese word *kaizen* that in translation means "step by step improvement" (Sallis, 1993: 36). As the research methodology is based on this model it is therefore apt that a full description of this model should be given (see figure 2.2).

Until only about 20 years ago most of the focus on quality had been in the manufacturing environment, with less attention given to service industries, and health care receiving the least attention (Naidoo & McSharry, 1999: 293). The concept of continuous quality improvement (CQI) was not well accepted by

administrators and providers of health care. Most of these health care employees were still thinking in terms of quality assurance instead of quality improvement. The process of quality assurance concentrated on trying to identify the problem systems and problem areas. Health care employees looked at themselves and each other, instead of the patients, to identify what to improve. They also battled with measurement issues. In summary the health care field was slow to commit to time and resources to understanding CQI theory and tools. Most of the early efforts in the late 1980's went into organising teams, even after some health care leaders began to look earnestly at CQI. In addition, far less effort was put in improving processes (Carey & Lloyd, 2001: 8).

The CQI Model requires that health care professionals first identify what to accomplish or to improve. In choosing the process that needs improvement the following questions can be posed, as the first step:

* What are we trying to accomplish?
* What change can we make that will result in improvement?
* How will we know that a change is an improvement?

The next step is to implement a common framework for thinking about the improvement process, which is called the FOCUS-PDSA process. The PDCA (Plan-do-check-act) cycle was conceived by Shewhart in 1939. This cycle was changed by his friend and mentor, Deming to the FOCUS-PDSA (Plan-do-study-act) cycle. This cycle is a tool for the use in the continuous improvement cycle (Bonstingl, 1996: 59-61; Evans & Lindsay, 1996; Naidoo & McSharry, 1999). Bonstingl (1996: 59-61) also asserts that the FOCUS-PDSA cycle is the way people learn and a never-ending commitment to improvement of quality. The FOCUS-PDSA cycle has as its essence the notion of continuous improvement – a key dimension to the philosophy of quality improvement. The PDSA process is briefly described as:

Plan: Find a process to improve i.e. the physiotherapy accreditation programme. If it is difficult to pinpoint the problem, get help from an external

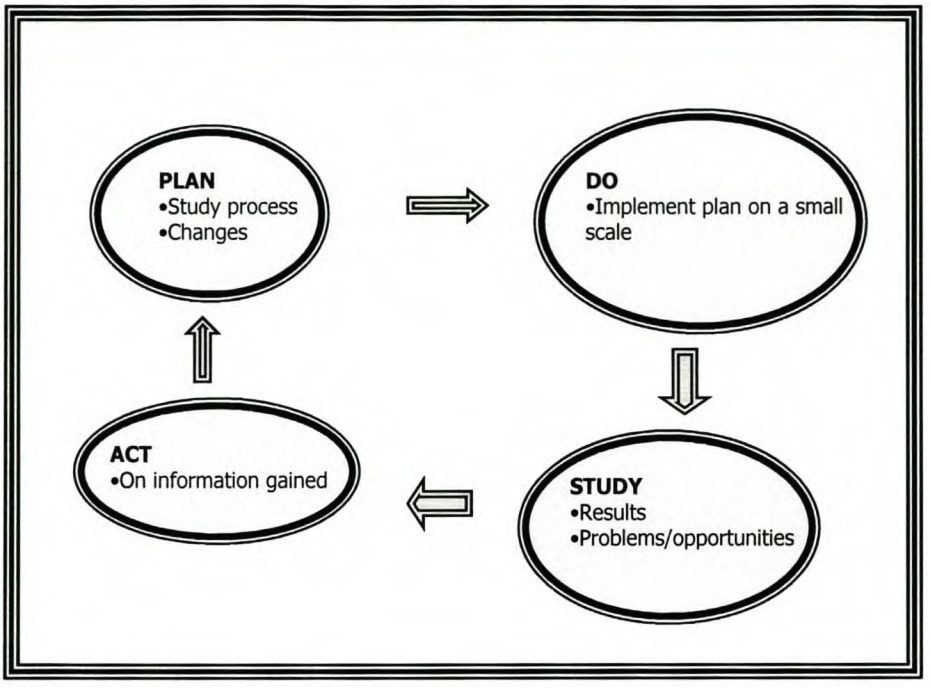
consultant to study the process, determine what changes would most improve the process, and enact a plan for making the improvement. A flow chart may be utilised to highlight the steps in the process.

Do: Implement the plan on a small scale or trial basis. Select one practice to implement the accreditation programme.

Study: Analyse the results of the implementation to determine whether the plan is working correctly, and if any further problems or opportunities are discovered. Using the audit method to collect the information and organise a problem solving group discussion.

Act: Act on what you have learned. If the change is working, implement it on a larger scale. If the change is not working, start over or tackle a new problem by starting the cycle again. Choose the best option, implement and evaluate again. Act according to the evaluation to procure the best result.

Figure 2.2. The researcher's schematic presentation of the Continuous Quality Improvement Model utilising the PDSA Cycle.



2.4.4.5.ii. The World Health Organisation (WHO) Model

The WHO (World Health Organisation, 1983; 10-16) quality improvement model (see Figure 2.3.) is three dimensional and includes the following components:

- A high quality health service delivery, including professional service, effective utilisation of resources, risk management and patient satisfaction. In the private physiotherapy practice quality service delivery is determined by implementing infection control measures, as well as employing staff that are competent and effective. Patient satisfaction is determined by means of patient questionnaires.
- The service is delivered on four levels, namely: self care, primary, secondary and tertiary care. Patients are educated and rehabilitated regarding different conditions e.g. in the asthma patient, the patient is taught how to do breathing exercises and how to use the prescribed equipment (i.e. nebuliser or mouth pump) effectively. The physiotherapy service delivery thus takes place on all levels of care.

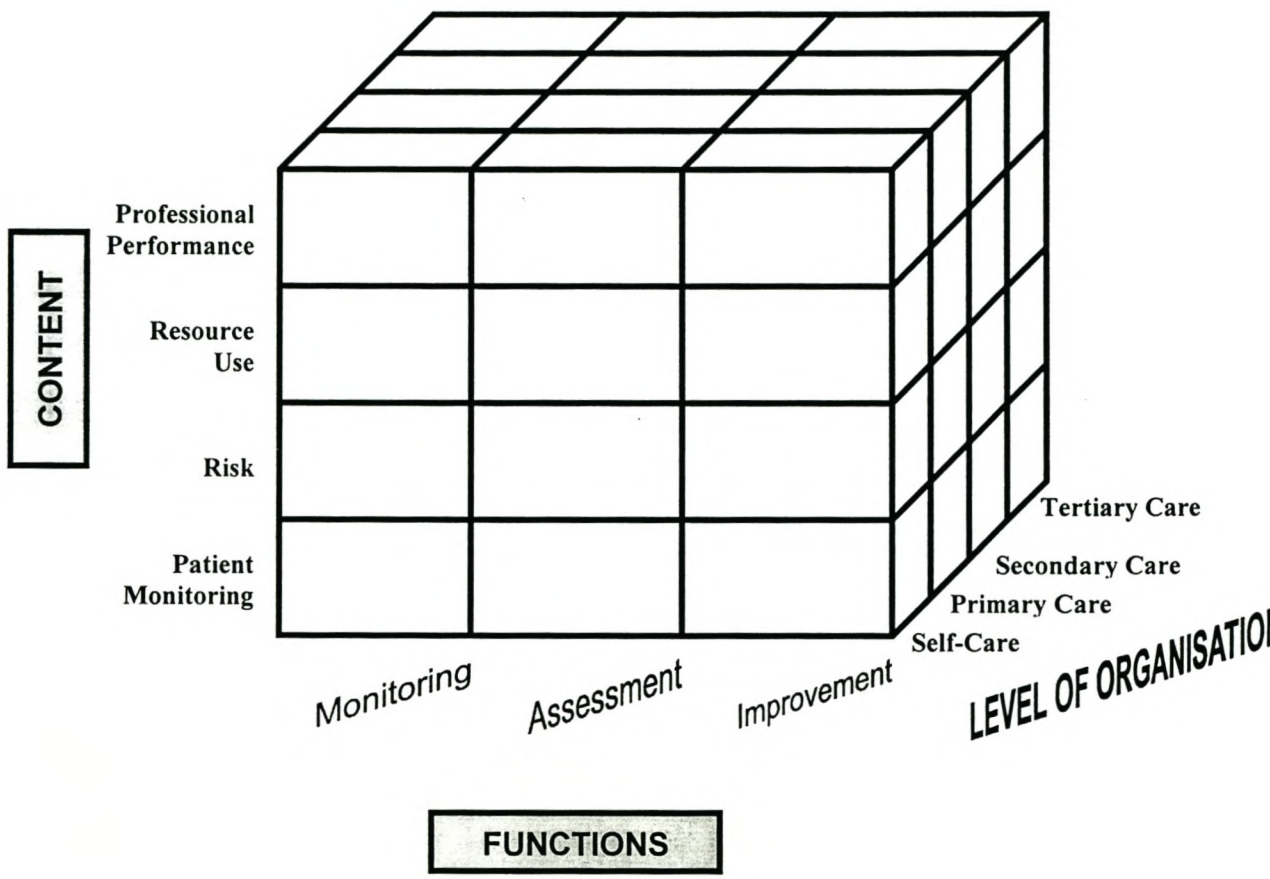
- Quality improvement activities include the following: monitoring of health care, analysing the data, identification of problems regarding care and the correcting the problems where possible, taking into account the changes which take place in organisational behaviour from time to time (WHO, 1983: 10-16). A QIP is implemented as part of an accreditation programme.

The WHO European Work Group has investigated the reasons for the implementation of quality improvement programmes. The Work Group found that the desire for quality improvement is based on the following:

- Professional factors: The pursuit of excellence and the desire to regulate one's own performance (WHO, 1983: 3).
- Social factors: Health practitioners have a responsibility towards their patients and the public to provide service of a high standard. The introduction of quality improvement programmes is essential to ensure the safety of patients and to protect the public from ineffective, substandard or even harmful practices (WHO, 1983: 3-4).
- Pragmatic factors: Quality improvement programmes are essential for an organisation to realise its stated mission. It should be able to be proven that a high quality service exists. A vast amount of data is currently available to organisations with quality improvement programmes. This data can be utilised to solve problems and achieve long-term goals (WHO,1983: 4).
- Public accountability: To be able to demonstrate an awareness of its accountability towards the public, an organisation needs a formal mechanism for the evaluation and improvement of the quality care rendered to the public.
- Improving management systems: Quality improvement programmes should be implemented in a positive way to improve the organisation's service management system through effective problem solving approaches. Shortcomings with regards to technical quality, effectiveness, the elimination of risks and patient satisfaction should be assessed. Management strategies should be designed and implemented to solve the encountered problems.
- Facilitation of innovation: Quality improvement activities stimulate resourcefulness. Staff should be afforded the opportunity to initiate and

implement innovations which address the key components of quality improvement in an organisation (WHO, 1983: 3-6).

Figure 2.3. The World Health Organisation Matrix Model for Quality Improvement (WHO,1983:10-16)



2.4.4.5.iii. The Australian Physiotherapy Association model for Quality Improvement.

A quality management activity can be set up as five steps (see figure 2.4.).

Step one: Monitor

Monitoring is the routine collection of information about aspects of service delivery. Monitoring refers to any systematic, ongoing process of collecting information on clinical and non-clinical performance. This is where the topics for review are identified and subsequently monitored. Topics for review could be one of two types:

- An already identified area of concern, for example, fall in patient numbers; and/or
- A major aspect of care that is known to be important, but is being monitored for verification of compliance with a particular standard, for example, all clinical record entries being signed and dated.

Practice principles should focus regularly on all aspects of clinical skills and operations of systems in the practice management. This may be through enquiries from or discussion with your staff, patients, referrers and all internal/external customers.

The key to the question to be asked is: *"What needs to be improved with our delivery of service?" "How can I or we make it better?"*

Step 2: Assess

This involves the analysis and interpretation of the information that is collected. This stage is often neglected. After successfully implementing systems for collecting data, the material must be analysed to identify trends of existing problems and subsequently implement changes.

One should assess the information collected during the monitoring phase by examining and measuring/rating the data to identify and rank the action(s) that would improve the outcome. Be sure to select the *most* significant and feasible action. It is usually best not to implement more than one action at a time to ensure a valid measurement of outcome.

Step 3: Act

When opportunities for improvement or particular problems are identified, actions are then taken and documented.

It may be that this is actually the refinement of existing practice processes or procedures for the purpose of "doing better what is currently being done", as well as the identification of actual or potential problems.

The most significant action should be implemented and the outcome *re-assessed.*

Step 4: Evaluate

Once an action has been implemented, it is important to demonstrate that the action actually did modify the care, service or outcome in the expected manner. This involves a review of the actions taken to ensure they were appropriate. The result of the evaluation will hopefully show that the issue was altered to an acceptable level.

Evaluating the effectiveness of the action will ensure that the outcome compares appropriately with that established in the *assessment* phase.

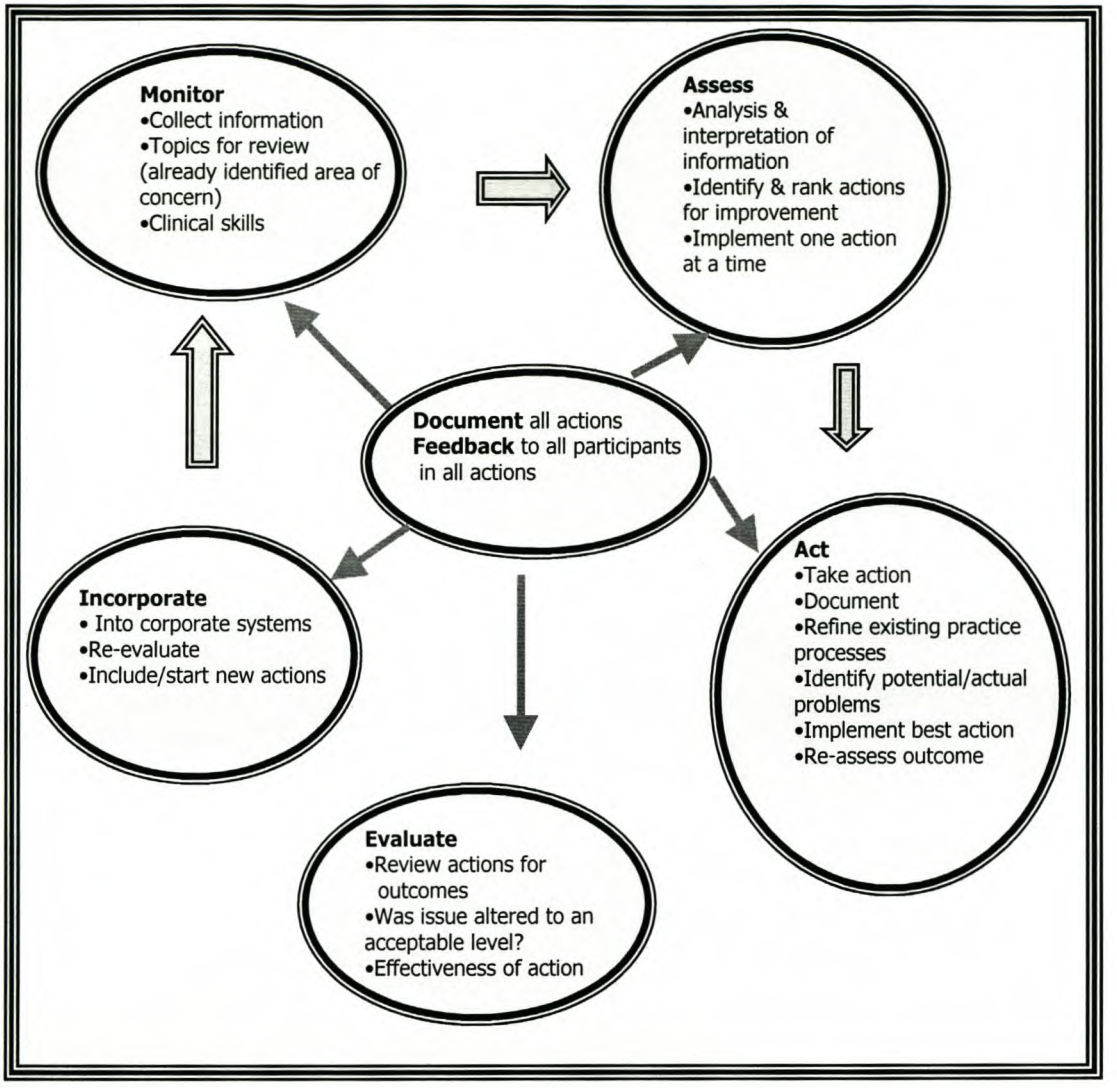
Step 5: Incorporate

Finally, if the outcome is positive, the actions must be effectively incorporated into the practice's systems and procedures.

A *re-evaluation* may be necessary to ensure the outcome has been effectively incorporated. If you decide that further improvement is desirable (and presumably attainable), then the next highest ranking *action* may need to be introduced and the same steps of *action* and *evaluation* repeated.

Formalising the process will include documentation and feedback. Appropriate and adequate documentation is a most important step in formalising the process. Recording specific and sufficient data of each stage is essential to the validity of the results and to be able to compare results/outcomes at subsequent follow-ups. Documentation also provides evidence of ongoing QI activities when applying for accreditation, as well as during survey.

Figure 2.4. The researcher's schematic presentation of the Australian Quality Management Model for Physiotherapy Practice



From the literature research on foundations of professional physiotherapy, legislation, OBE and QI, provisional empirical indicators have been identified, which were utilised to compile an evaluation checklist. See Table 2.22. for the empirical indicators for quality improvement for the utilisation of in the evaluation of the accreditation programme for physiotherapy practice.

Table 2.22. Summary of Empirical Indicators for Evaluation of a Physiotherapy Accreditation Programme.

Foundations of professional physiotherapy practice in South Africa	Legislative framework for professional physiotherapy in South Africa	Outcomes-based Education (OBE)	Quality Improvement & Accreditation
• Boundaries of exclusiveness ⇒ Specific training requirements ⇒ Practice standards ⇒ Registration • Theory and practical training ⇒ Physical (physiotherapy science, applied physiotherapy, clinical physiotherapy) ⇒ Social (community) ⇒ Business management • Registration with HPCSA • Professional association: SASP • Professional Board of Physiotherapy (PB): standards • Ethical rules: PB • Disciplinary steps: PB • Scope of practice: PB • Community physiotherapy • Independent practitioners – accountable for acts or omissions • Trust relationship • Transformation according to the health policy • Up to date knowledge • Bound by Hippocratic Oath • Sustained excellence through standards	• SAQA Act 58 of 1998 • Medical, Dental and Supplementary Health Services Act No 56 of 1974 ⇒ Scope of physiotherapy practice and specific procedures[section 33(1)] ⇒ Acts or omissions [section 52(2)] • Occupational Health and Safety Act No 85 of 1993 • Basic conditions of Employment Act No 75 of 1997 • Employment Equity act No 55 of 1998 • Health Act No 63 of 1977 • Human Tissue Act No 65 of 1983 • Pharmacy Act No 53 of 1974 • The Medical Schemes Act No 131 of 1998 • Commission for Occupational Injury and Diseases Act No 130 of 1993 • Higher Education Act No 101 of 1997 • Skills Development Act No 97 of 1998	• Purpose of OBE •Emphasis • Principles ⇒ Clarity of focus ⇒ Expanded opportunity ⇒ High expectations ⇒ Design down process • Specific learning areas/roles • Outcome result/product • Demonstrate outcomes ⇒ High quality ⇒ Culminating ⇒ Significant learning ⇒ Contextual • Exit outcomes • Specific outcomes • Assessment principles ⇒ Summative (continuous monitor and feedback) ⇒ Performance based (authentic) • Criterion-references (assessment criteria) • Criteria for assessment of competence (demonstration) ⇒ High quality ⇒ At a culminating end point ⇒ Show evidence of significant learning ⇒ In context / performance setting	• QI model • QI committee • QI programme • Basic components ⇒ Philosophy ⇒ Value framework ⇒ Mission of scope of service ⇒ Management and direction ⇒ Personnel structure and development ⇒ Operational policies & procedures ⇒ Facilities & equipment ⇒ Quality Improvement •Principles ✣Team approach ✣ Goal ✣ Applicable resources ✣ Critical factors ✣ Documentation ✣ Group pressure for change ✣ Involvement of top management • Standards ⇒ Structure ⇒ Process ⇒ Outcome • Standard formulation (valid & reliable) • Performance monitoring and evaluation (audit and observation) • Remedial actions in service • Dimensions of quality ⇒ Client quality ⇒ Professional quality ⇒ Management quality ✣ Plan services ✣ Implementation ✣ Evaluation • Broad approaches to quality ⇒ Exceptional ⇒ Perfection ⇒ Fit for purpose ⇒ Value for money ⇒ As transformation

Table 2.22. Summary of Empirical Indicators for Evaluation of a Physiotherapy Accreditation Programme, cont.

Foundations of professional physiotherapy practice in South Africa	Legislative framework for professional physiotherapy in South Africa	Outcomes-based Education (OBE)	Quality Improvement & Accreditation
			• Performance ✣ Quantity ✣ Quality (errors & appearance) ⇒ Infection control ⇒ Patient education ✣ Timeliness ⇒Deadlines ⇒ Absenteeism ⇒New approaches ⇒Cost-effectiveness ⇒ 3 M's (money, men & materials)

2.5. SUMMARY

In this Chapter the literature research was described according to the foundations of professional physiotherapy practice in South Africa, the legislative framework for professional physiotherapy in South Africa, OBE and quality improvement and accreditation. Empirical indicators were identified for utilisation in the evaluation of the accreditation programme for physiotherapists in South Africa.

In Chapter three the research methodology for the evaluation of an accreditation programme for the South African private physiotherapy practice is described.

Chapter Three

Research Design and Methodology

Nothing can be loved or hated unless it is first known. LEONARDO DA VINCI, Notebooks (c 1500).

3.1. INTRODUCTION

As the cost of health care is ever increasing, quality improvement programmes are essential to ensure that quality of care is maintained and that quality service is delivered at all times. This need for quality improvement is also emphasised by the constant changes in the health care environment. In this Chapter the research design and methodology is described. In this research the methodology is qualitative in nature.

Qualitative research methods result in rich, thick descriptions of participants' subjective experiences. By bringing into the equation the perceptions of the interest of the participants themselves, new light is thrown on issues in a way that could not be done through other techniques. Conventional research methods (quantitative) investigates the physiological effectiveness of an intervention, where as qualitative methods explore whether the people exposed to the intervention may understand what it means and may see it in relationship to other priorities in their lives and ultimately may choose whether they value it enough in order to comply (Ritchie, 1999: 253).

Ritchie (1999: 253) and Brink (1993: 35) further emphasize that quality qualitative research should include the following:

- Qualitative research should seek specific and unique samples where the most information can be gathered and the most can be learnt, rather than samples that are representative or general;
- Qualitative research has different properties and should be evaluated for qualities of credibility and trustworthiness, rather than conventional standards of validity, reliability or objectivity; and
- Triangulation to reinforce the findings by using more than one source of data, methods, theoretical perspectives and approaches to analyse the data.

In this Chapter the research method, for the evaluation of an accreditation programme for quality improvement in private physiotherapy practice in South Africa is described according to the Research Model (Botes, 1998; 2000) to be ultilised in the research.

3.2. GOAL OF THE RESEARCH

The research goal is to evaluate the PhysioFocus accreditation programme and to make recommendations on the learning programme for accreditation in private physiotherapy practices.

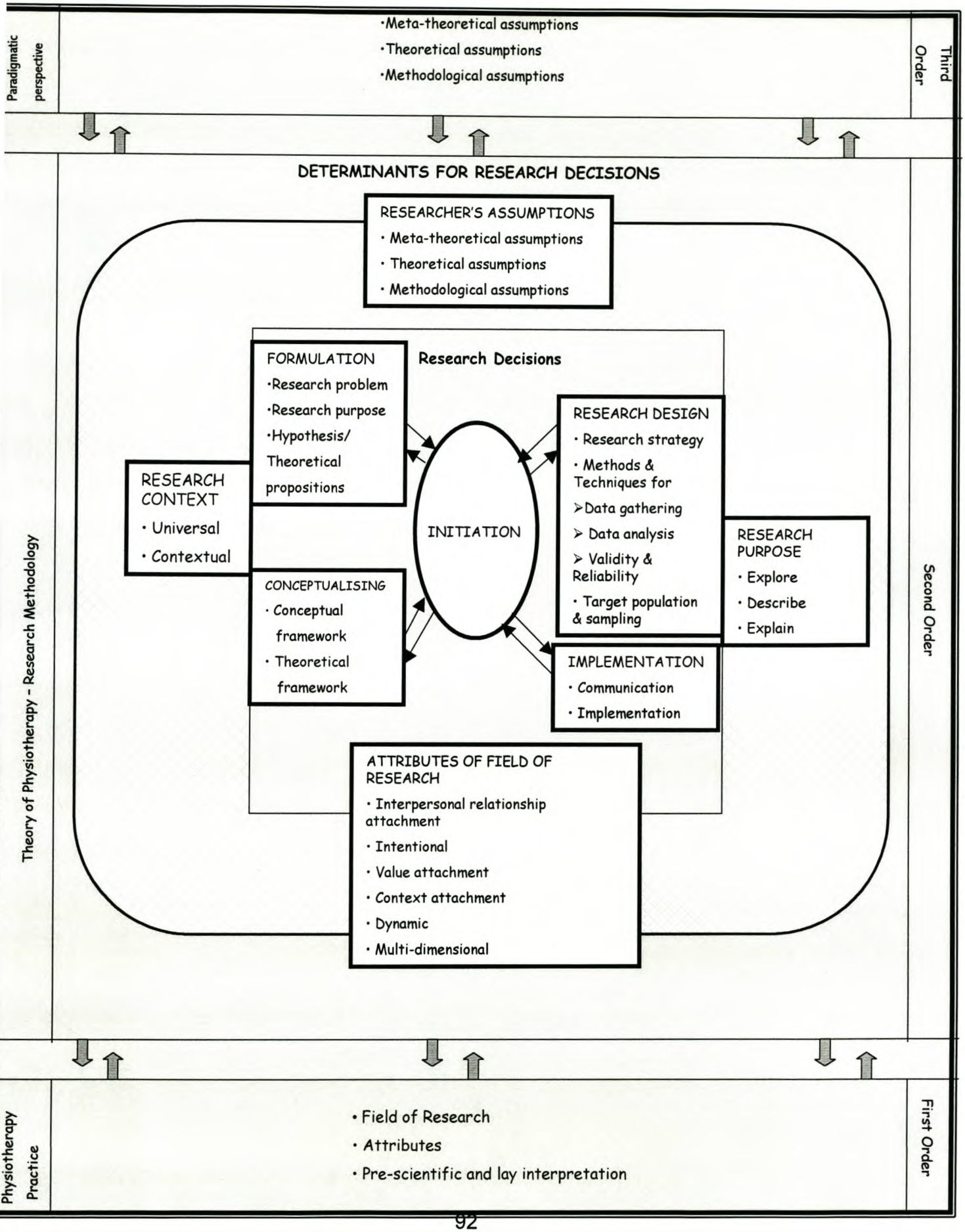
The objectives of the research were divided into three phases, namely:

- Phase one: to explore the literature on accreditation and quality physiotherapy practice in order to identify empirical indicators for the development of a provisional evaluation instrument for the PhysioFocus practice accreditation programme ;
- Phase two: to identify remedial actions to be implemented in the learning programme for accreditation in private physiotherapy practices. This phase was conducted by means of an open-ended, semi-structured questionnaire (see Appendix three) which was completed by the physiotherapists in the target population. The results were analysed and recommendations made; and
- Phase three: to evaluate the accreditation programme implemented in selected voluntary private physiotherapy practices. A provisional evaluation instrument (see Appendix one) was formulated according to the empirical indicators identified in phase one. The provisional evaluation instrument was sent to the physiotherapy experts for validation. The recommendations from the expert physiotherapists were implemented and a final evaluation instrument (see Appendix two) formulated. The final evaluation instrument was utilised to evaluate the PhysioFocus practice accreditation programme.

3.3. RESEARCH METHOD

The Botes (1998; 2000: 15) Research Model (see Figure 3.1.) was utilised, to guide the research process according to the practice and the paradigmatic perspectives. The Botes Research Model (1998; 2000: 15) provides a holistic perspective of the research process, rather than a detailed description of the methods and techniques of the research. For this reason the model lends itself to both qualitative and quantitative research methodologies (Botes, 1998; 2000: 9). The rationale for using this model is its simple, practical, yet comprehensive application to the situation under research. It is designed for South African Health Care Research. The model presents the activities of physiotherapy on three different levels or orders.

Figure 3.1. The Botes Research Model (Botes, 1998; 2000)



The model consists of three interacting orders, with the first order being the health care practice, the second order the determinants of the research decisions (the research methodology) and the third order the paradigmatic perspective. See Table 3.1. for the relationship between the physiotherapy practice, the science of physiotherapy and the philosophy of physiotherapy science.

Table 3.1. The Relationship Between the Physiotherapy Practice, the Science of Physiotherapy and the Philosophy of Physiotherapy Science

Third order	The philosophy of physiotherapy/researcher (meta-theoretical/methodological activities)
Second order	Physiotherapy as applied in physiotherapy practice (scientific application)
First order	Reality Physiotherapy practice (interaction) (pre-scientific interpretation)

Simultaneously with the description of the Botes Research Model (1998; 2000: 15) according to the three research orders, the application of the research methodology for the research of the evaluation of an accreditation programme for quality improvement in private physiotherapy practice in South Africa, is described.

3.3.1. First Order – Physiotherapy Practice

The first order of this model includes the field of physiotherapy practice. This includes all the disciplines of physiotherapy, physiotherapy management and physiotherapy education. The practice situation is thus the primary source of the research. The physiotherapy practice has certain characteristics which make demands on how the research should be conducted. These characteristics then serve as determinants for research decisions. The physiotherapy practice is constituted by the physiotherapist who is in interaction with the patient. Whilst the physiotherapist pursues the practice largely from the basis of physiotherapy, there are also pre-scientific interpretations of the physiotherapist that influences the nature of the practice. In a related way, the lay interpretations of the patient influences the patient's health behaviour. The researcher must take note of these interpretations in order to get a more complete understanding of physiotherapy practice. The researcher should analyse, evaluate and test these

interpretations. If they are found to be true, they will become part of the knowledge base of physiotherapy (Botes, 1998; 2000: 9). The first order includes the field of research, attributes of the practice to be researched and the pre-scientific and lay interpretation of the research to be done. See Table 3.2. for the application of the first order to physiotherapy practice.

Table 3.2. Application of the First Order to Physiotherapy Practice (Botes, 1998, 2000: 9)

Criteria	Application
Field of research	Private physiotherapy practice in South Africa
Attributes	- Employer: Practice Principal/manager (registered physiotherapist) - Employees: • Registered physiotherapists • Administrative staff • Domestic staff - Service hours: Flexible - Service provision: 24 hours - Service delivery: - at the physical address, hospitals, clinics, home visits, sporting events, community - All registered physiotherapy staff are responsible and accountable for the quality of physiotherapy services rendered - All registered physiotherapy staff are voluntary committed to quality service. - Procedures: See Table 2.7 - Scope of profession: See Table 2.6 - Account Rendering: Private, Board of Health Funders (BHF) & Occupational and Diseases Act No 130 of 1993. - Acts applicable to physiotherapy (see Chapter two)
Pre-scientific and lay interpretation	Accreditation is seen as value for money, improved quality service, improved practice management, quality improvement, insight into practice activities and proactive problem solving actions.

3.3.2. Second Order – Research Methodology

The researcher functions at the second order of the model and is continually in interaction with the practice situation. It can be said that physiotherapy practice influences the research to a large extent, in the same way as research provides guidelines for practice. The inter-dependence of research and practice are emphasised this way. The researcher is co-responsible for physiotherapy practice. The physiotherapist in practice is in turn responsible for the application of knowledge, generated through research and theory formulation, into physiotherapy practice in order to confirm the usefulness of the new knowledge (Botes, 1998; 2000: 9). The aim of research is to improve the practice of the discipline, in this case the practice of physiotherapy as evidenced in the practice accreditation programme (Botes, 1995: 5).

The second order of the research model represents the theory of physiotherapy and the research methodology. The activities in this case are research and theory development. Theory development is seen as the continuing and extended process of research. Detached statements are arranged into a conceptual framework in order to attain a clearer understanding of physiotherapy practice. The goal of research and theory development is functional by nature in that the knowledge of physiotherapy that is generated, is applied in physiotherapy practice. Research methodology is described as the research decisions that are taken within the framework of the determinants for research decisions. The determinants of research are the characteristics of the research domain, the assumptions of the researcher, the research objectives and the research context. The aspects about which research decisions are made, are initiation, formulation, conceptualisation, research design, research communication and implementation. Determinants of research decisions are described according to:

- the research purpose;
- the attributes of the field of research;
- the research context;
- the research assumptions;

- the research decisions; and
- the implementation of the research.

3.3.2.1. Research Purpose

The Botes Research Model (1998; 2000: 15) distinguishes between three strategies when describing the research purpose. These are exploratory, descriptive and explanatory strategies with a qualitative orientation. The following Table 3.3. depicts Neuman's (2000: 22) view of the dimensions of purpose of research.

Table 3.3. Goals of Research (Neuman, 2000: 22)

Exploratory	Descriptive	Explanatory
Familiarise self with the basic facts, settings and concerns	Describe a detailed, highly accurate picture	Evaluate a theory's prediction or principle
Establish a general mental picture of conditions	Procure new data that contradict past data	Provide a thorough description of the theory
Formulate and clarify questions for future research	Generate a set of categories or classify types	Increase the scope of a theory to new issues or topics
Produce new ideas	Define a sequence of steps or stages	Support or reject an explanation or prediction
Establish the feasibility of conducting research	Record a causal process or mechanism	Connect issues or topics with a general principle
Generate techniques for measuring and locating future data	Report on the setting or context of a situation	Determine the best explanation

3.3.2.1.i. Exploratory

Mouton and Marais (1990: 45) and Uys and Basson (1996: 25) state the goal of an exploratory study as the exploration of a relatively unknown field of study. The aims of exploratory studies are diverse, namely:

- to gain new insight into the phenomenon;
- as a pre-investigation for a more structured investigation of the phenomenon;
- to construct and define central concepts; and
- to develop new hypotheses regarding an existing phenomenon.

The methods that can be utilised in an exploratory study are:

- an overview of existing applicable literature;
- a survey of experts on the field of research; and
- an analysis of insight stimulating research matter.

A global literature research was done and empirical indicators were identified. The empirical indicators were implemented to evaluate the physiotherapy practice accreditation programme. Furthermore, a survey was conducted amongst physiotherapists regarding the physiotherapy practice accreditation learning programme.

3.3.2.1.ii. Descriptive

According to Mouton and Marais (1990: 46) and Uys and Basson (1996: 25) descriptive research include a variety of research methods such as experimental, non-experimental, quasi-experimental and survey methods. These methods can include qualitative or quantitative strategies. The difference in strategy lies in research with a contextual interest and research with a universal interest. According to Wolcott (1994: 12) descriptive research addresses the question, "What is going on here?". Data consist of observations made by the researcher and/or reported to the researcher by others. See section 3.3.2.5.iii.a. for the application of the FOCUS-PDSA strategy.

In this research, a qualitative research approach was adopted. Qualitative inquiry focuses on the meaning of the context and requires a data collection instrument that is responsive to the underlying meaning when gathering and interpreting data (Merriam, 1998: 1; Denzin & Lincoln, 1998a: 55). Humans are the best suited for this task, especially because interviewing, observing and analysing are activities central to qualitative research. In such research the data are soft and based on impressions, interpretations, perspectives and prejudices of the participants. It assumed that the meaning is rooted in the experience of people and that this meaning is mediated through the investigator's own perceptions. Patton (1985: 1) explains: "[Qualitative research] is an effort to

understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself, so that is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting – what it means for the participants to be in the setting, what their lives are like, what's going on for them, what their meanings are, what the world looks like in that particular setting – and in the analysis to be able to communicate that faithfully to others who are interested in that setting ..... The analysis strives for depth of understanding."

Qualitative researchers are interested in understanding the meaning people have constructed – how they make sense of their world and the experiences they have in the world. The main concern is the understanding of the phenomenon of interest from the participant's perspective and not the researcher's perspective (which is an insider's perspective). Table 3.4. summarises the characteristics of qualitative research (Merriam, 1998: 9).

Table 3.4. Characteristics of Qualitative Research (Merriam, 1998: 9)

Action	Characteristic
Focus of research	Quality (nature, essence)
Philosophical roots	Phenomenology, symbolic interaction
Associated phrases	Field work, ethnographic, naturalistic, grounded, constructivist
Goal of investigation	Understanding, description, discovery, meaning, hypothesis generating
Design	Flexible, evolving, emergent
Sample	Small, non-random, purposeful, theoretical
Data collection	Researcher as primary instrument, interviews, observations, documents
Mode of analysis	Inductive (by researcher)
Findings	Comprehensive, holistic, expansive, richly descriptive

3.3.2.1.iii. Explanatory

The aim of explanatory research is to identify the cause between variables and incidences (Mouton & Marais, 1990: 47; Uys & Basson, 1996: 27). Explanation builds on exploratory and descriptive research and goes on to identify the reason something occurs. Going beyond focusing on a topic or providing a picture of it, explanatory research looks for causes and reasons. (Neuman, 2000: 22). The researcher has adopted a partially explanatory approach to determine optimal implementation of the physiotherapy practice accreditation

programme by means of the learning programme. An open-ended questionnaire was utilised to identify problem areas and recommendations for improvement of the physiotherapy practice accreditation programme. The questionnaire consisted of eleven open-ended questions with a section for recommendations (see Appendix three for the questionnaire).

3.3.2.2. Attributes of Field of Research.

According to Botes (1995: 6) the attributes of the field of research consist of the following:

- Interpersonal relationship attachment is determined by the structure of the private physiotherapy practice, as described in Table 3.2.
- The physiotherapist functions as an independent practitioner as regulated by the Medical, Dental and Supplementary Health Act. The physiotherapist is responsible and accountable for quality physiotherapy delivery. All the employees attached to the physiotherapy practice subscribe to this philosophy of quality service delivery.
- Value and context attachment is found in the professional, ethical attachment of the registered physiotherapist as regulated by the Medical, Dental and Supplementary Health Act. The physiotherapy practice accreditation programme may differ according to the philosophy and values of a specific physiotherapy practice. Trans-cultural influences determine the value and attachment regarding the quality of physiotherapy service delivery.
- Dynamics and multi-dimensionality is found in the voluntary commitment to the activities of practice accreditation. The personal and professional development of the physiotherapist is a dynamic process in the establishment of quality physiotherapy delivery.

3.3.2.3. The Research Context

The context of the research has a universal as well as a contextual determinant (Botes, 2000: 12; Mouton & Marais, 1990: 46). The universal determinants are found in the universal theoretical overview of the literature (see table 3.8.).

The contextual determinant of this study includes the foundations of professional physiotherapy, OBE, legislation and quality improvement with accreditation for physiotherapists in private practice in South Africa. In 1994 PhysioFocus, the Private Practitioners Association of the South African Physiotherapy Society (SASP) unanimously decided to embark on a practice accreditation programme for physiotherapists in private practice. The programme developed by the Australian Physiotherapy Association was acquired in 1996 after deciding that it would be too time consuming and costly to develop a new programme. This programme was adapted to suit the private practice situation in South Africa, bearing in mind registration requirements, building regulations, fire regulations and electrical requirements as laid down by the South African Bureau of Standards (SABS).

This task was completed in 1997 at exactly the same time as the Australian version was updated. The PhysioFocus Accreditation Committee decided to acquire the update and to incorporate it into the final South African version. This task was completed in 1998 and the programme was ready for implementation from June 1999.

3.3.2.4. Research Assumptions

No research is value-free and it is for this reason that the researcher states her assumptions. Qualitative research is interpretive research (Creswell, 1994: 147). The thoughts and activities of the research are directed by the values of the researcher. The researcher selects certain assumptions from the paradigm perspective in response to her interaction with the research field. Neuman (2000: 44) argues that concepts contain built-in assumptions, statements about the nature of things that are not observable or testable. Concepts and theories build on assumptions about the nature of human beings, social reality or a particular phenomenon. Assumptions often remain hidden or unstated. The research assumptions are described according to the researcher's assumptions. Botes (2000: 10) identified research assumptions according to meta-theoretical, theoretical and methodological assumptions. These are realised as follows in the third order of the model:

- Meta-theoretical: The meta-theoretical assumptions are not testable and deal with the human being and society. These assumptions have their origin in philosophy. Although these assumptions give no epistemic statements, they influence the research throughout. The researcher approached the study from a Judeo-Christian perspective (see section 2.3.1.).
- The theoretical assumptions generated from the ALM, which is described in the third order. The theoretical assumptions are testable and offer epistemic statements about the research field. These assumptions contain statements of the research field and form part of the existing and accepted theory of physiotherapy. Theoretical assumptions give structure to the central theoretical assumption as well as to the conceptual framework of the study. Theoretical assumptions derive from a thorough literature research (see Chapter two). In some qualitative studies the theoretical assumptions can only be made after the data gathering and data analysis processes have been completed (Botes, 1995: 6).
- Methodological: These assumptions have their origin in science-philosophy (Botes, 1995: 7). They deal with purpose, methods and criteria for the validity of the research. Methodological assumptions concern the researcher's view of the nature and structure of science and research in physiotherapy. The researcher has no preferences. The FOCUS-PDSA cycle (**f**ind a process to improve, **o**rganise an effort to work on improvement, **c**larify current knowledge of the process, **u**nderstand process variation and capability, and **s**elect a strategy for improvement) is a practical quality improvement tool for use in a quality improvement / accreditation process, therefore the FOCUS-PDSA cycle was utilised in this research.

3.3.2.5. Research Decisions

The research decisions must be taken within the framework of the determinants of research in order to be justified. There must be a logical relationship between the determinants and the research decisions.

Botes (2000: 12-14) describes the following concepts as part of the research decisions:

- initiation;
- formulation of a research problem;
- research design;
- implementation of the research; and
- conceptualisation.

3.3.2.5.i. Initiation

The researcher starts the research process with the initiation phase with a research theme or research topic (Botes, 2000: 13). The research subject is considered in terms of the determinants of research. In this phase the following aspects are relevant:

- background and rationale for the research;
- problem statement;
- purpose of the research;
- central theoretical assumption;
- conceptualisation and the research design; and
- planning for the research.

The researcher moves between the research decisions according to the demands of the research subject (see Chapter one for the initiation phase of this research).

3.3.2.5.ii. Formulation of the Research Problem

Formulation of the research problem, purpose and theoretical propositions were described in Chapter one (see section 1.2.) with the formulation of the following central theoretical assumption:

The evaluation of the accreditation learning programme for quality improvement in private physiotherapy practice in South Africa should facilitate:

- quality physiotherapy practice;
- professional and personal development;
- monitoring of the progress of the pre- and post accreditation process; and
- monitoring and remediation of continuous changes in private physiotherapy practice.

3.3.2.5.iii. Research design

The research design included the following: a research strategy; data gathering and data analysis methods; trustworthiness (validity and reliability) strategies; and population and sample.

3.3.2.5.iii.a. Research Strategy

The strategy implemented in this research was the continuous quality improvement model, also known as the FOCUS - PDSA cycle (see section 2.4.4.5.i.) for a full description of the model). Table 3.5. describes the implementation of the FOCUS - PDSA cycle as the research strategy.

Table 3.5. Implementation of the FOCUS Steps as the Research Methodology for the Evaluation of the PhysioFocus Practice Accreditation Programme

Steps	Criteria	Research Action
1. Find a process to improve.	Plan	• The process is to evaluate the PhysioFocus practice accreditation programme (the programme).
	Do	• Do literature research, identify and compile empirical indicators for the evaluation instrument.
	Check	• Identify practice experts, according to specific criteria (see 3.2.2.5.iii.c). • Supply experts with a copy of the provisional evaluation instrument for validation, instructions, report format & return date.
	Act	• Validation of the evaluation instrument by practice experts by utilising Lynn's (1986: 383) criteria for validity and reliability of experts.
2. Organise an effort to work on improvement	Plan	• Implement recommendations by experts to the evaluation instrument. • Communicate the final evaluation instrument to experts. • Set a date and venue for evaluation of the programme. • Invite physiotherapy experts in quality improvement (QI) and accreditation to evaluate the programme.
	Do	• Collect programme and final evaluation instrument.
	Check	• Ensure items mentioned in plan above are in place and date and venues of evaluation of the programme are available.
	Act	• Implement all of the above.
3. Clarify current knowledge of the process.	Plan	• Supply the physiotherapy QI experts with a copy of the programme and evaluation instrument for perusal before evaluation date.
	Do	• Evaluate the programme together with the physiotherapy QI experts.
	Check	• Check that all the relevant report documentation is in place.
	Act	• Use a problem solving approach to identify areas in need of improvement, alternatives and solutions, to compile the final report.
4. Understand the process variation and capability.	Plan	• Communicate recommended improvements contained in the final report to the PhysioFocus accreditation committee.
	Do	• Set up a meeting with PhysioFocus accreditation committee for feedback on evaluation report.
	Check	• Notify committee members of date, time and venue of the meeting.
	Act	• Implement all of the above.
5. Select a strategy for improvement.	Plan	• Analyse the report and suggestions for implementation of recommendations.
	Do	• Analyse the implications of recommended changes and suggestions. • Committee decides on applicable recommendations and how, when and where implementation will take place.
	Check	• Check that structures for implementation of improvements are available, i.e. private practices to implement improvements.
	Act	• Implement applicable recommendations within a certain time frame. • Implement FOCUS steps as part of the evaluation process.

3.3.2.5.iii.b. Data Gathering and Data Analysis

The data gathering and data analysis were done simultaneously. The first method of data gathering was by means of a literature research, which included, professional physiotherapy practice, OBE, legislation and quality improvement including accreditation. Empirical indicators were identified to evaluate the physiotherapy practice accreditation programme (see Table 2.22.). The Activities of Living Model (Roper et al., 2000) was utilised as part of the conceptual framework for the development of the evaluation instrument.

Secondly, an open-ended questionnaire was compiled to gather the data for the identification of problem areas and recommendations for improvement of the physiotherapy practice accreditation learning programme. The questionnaire consisted of eleven open-ended questions with a section for recommendations (see Appendix three for the questionnaire). The data is interpreted in a partial explanatory format.

The strategies of reasoning implemented in identifying the empirical indicators and compiling the questionnaire were analysis, deduction, induction, derivation and synthesis and are briefly summarised in Table 3.6. below.

Table 3.6. Strategies of Reasoning

Strategies of reasoning	Description
1. Analysis	Clarification and refining of objects, assumptions and theories (Wolcott, 1994).
2. Deduction	The process of developing specific predictions from general principles of belief (Abdellah & Levine, 1979).
3. Induction	This is the logical process whereby a probable conclusion, depending on external confirmation, is reached (Creswell, 1994)..
4. Derivation	This implies analogies and metaphors during the transposition or redefinition of concepts, statements or theories from one context to another (Walker & Avant, 1988).
5. Synthesis	Isolated parts of theoretical information is combined to construct a new concept or statement (Walker & Avant, 1988).

- *Analysis* implies clarification and refining of concepts, assumptions and theories, especially where there is an existing source of knowledge. Concept analysis examines the attributes or characteristics of a concept and statement analysis examines the presentation form of the relational

statements and the relationship of concepts within the statements (Wolcott, 1994: 23).

- *Deduction* is described by Abdellah and Levine (1979) as the process of developing specific predictions from general principles of belief. Deduction is used when concepts are brought into relationship with each other.

- *Induction* is a logical process whereby a probable conclusion, depending on external confirmation, is reached. Creswell (1994:145) describes inductive reasoning as involving a process in which general rules develop or evolve from individual cases or observation of phenomena.

- *Derivation* implies analogies or metaphors during the transposition or redefinition of concepts, statements or theories from one context to another (Walker & Avant, 1988:24). Walker and Avant (1988: 25) further describe concept derivation as consisting of moving concepts from one field of interest to another. Statement derivation consists of deriving the content or structure of a set of statements in a field of interest, from another set of statements from another field of interest.

- *Synthesis* combines isolated parts of theoretical information to construct a new concept or statement (Walker & Avant, 1988: 27). Concept synthesis is described as a strategy to develop concepts based on observation or other form of empirical evidence. Statement synthesis is described as a strategy that aims to specify relationships between two or more concepts based on evidence.

3.3.2.5.iii.c. Trustworthiness

The trustworthiness of the study is based on the trustworthiness model of Lincoln and Guba (1985). Guba (1981) identified four aspects of trustworthiness namely:

- Truth value (credibility), which is based on the discovery of human experiences as experienced and observed by the respondents;
- Consistency (dependability) of data implies that the results will remain the same during repetition of the evaluation, using the same respondents.
- Transferability /applicability, where transferability implies an in-depth description of the results and the ability of other researchers to utilise the results in related research. Applicability, which refers to the extent in which the findings can be applied in other contexts, within other groups. It is the ability to generalise results with regard to bigger populations.
- Confirmability (neutrality) in reliability implies the freedom of prejudice in the research procedures and results.

Criteria that originate from the above four aspects are internal validity, external validity, trustworthiness and objectivity (Lincoln & Guba, 1985: 290). Pelto and Pelto (1978: 33) describe validity as the degree to which scientific observations actually measure or record what they purport to measure. Goetz and LeCompte (1984: 210) state that validity is concerned with the accuracy of scientific findings. According to the authors establishing validity requires: determining the extent to which conclusions effectively represent empirical reality; and assessing whether constructs devised by researchers represent or measure the categories of human experience that occur.

Internal validity is defined as the extent to which variations in a (dependent) variable can be attributed to controlled variation in an independent variable. Internal validity is referred to as " the approximate validity (the best available approximation of the truth or falsity of a statement) with which we infer that a

relationship between two variables is causal, or that the absence of a relationship implies the absence of a cause" (Cook & Campbell, 1979: 37). Threats towards the internal validity of a study are the following (Campbell & Stanley, 1963):

- The history: the specific external events that take place between the first and second measurement apart from the external variables.
- Maturation: processes operating within respondents as a function of time per se.
- Testing: The effects of taking a test upon the scores of a re-test.
- Instrumentation: Changes in the calibration of a measuring instrument, or changes in the observers or scores used.
- Statistical regression: The inclination to move to the mean when comparison groups have been selected on the basis of extreme scores.
- Differential selection: The effect of comparing fundamentally non-comparable groups.
- Experimental mortality: the effects of the differential loss of respondents from comparison groups, rendering them non-comparable.
- Selection-maturation interaction: An effect that in certain designs may be mistaken for the effect of the experimental variable.

The internal validity of a study requires that rival hypotheses that are represented by the above threats, must be declared invalid (Lincoln & Guba, 1985: 291). In this research a single questionnaire, containing eleven open-ended questions about the learning programme of the Physiofocus practice accreditation programme, was completed by the respondents. In this way seven of the eight threats to the internal validity of the study were eliminated (the history, testing/re-testing, instrumentation, statistical regression, differential selection, experimental mortality and selection-maturation-interaction). The only threat that is possibly applicable to this research, is that the researcher has been involved with the development and implementation of the physiotherapy practice accreditation programme since 1994.

Internal validity is replaced by the "truth value" or credibility, as suggested by Lincoln and Guba (1985: 300).

External validity is defined as the approximate validity with which we infer that the presumed causal relationship can be generalised to and across alternate measures of the cause and effect and across different types of persons, settings and times (Cook & Campbell, 1979: 37). It is the purpose of randomised sampling from a given, defined population to make this criterion attainable. If a sample is selected in accordance with the rule that every element of the population has a known probability of being included in the sample, then it is possible to assert that, within confidence limits, the sample will hold for the population (Lincoln & Guba, 1985: 291).

Threats to the external validity of a study according to LeCompte & Goetz (1982) are the following:

- Selection effects: Constructs being tested are specific to a single group.
- Setting effects: the fact that results may be a function of the context under examination.
- History effects: unique historical experiences may compromise comparisons.
- Construct effects: the constructs studied may be peculiar to the studied group.

The only possible threat to this study is the setting effects because the context is being examined in the literature research. In this research the following apply:

- Trustworthiness is accepted when each repetition of the application of the same, or supposedly equivalent, instruments to the same units, deliver the same result (Ford, 1975: 234 in Lincoln & Guba, 1985: 292). The trustworthiness of the study is heightened by the single questionnaire which respondents will complete according to their own experience and evaluation.
- Objectivity is determined by intersubjective agreement: when several observers reach independent agreement regarding a phenomenon, it can be agreed that their collective judgement is objective. Methodology is another method of objectivity, by using methods that by their character render the study beyond contamination by human interaction (Lincoln & Guba, 1985: 292).

External validity is replaced by transferability, reliability by dependability and objectivity by confirmability in the research as described by Lincoln and Guba (1985: 300).

The four strategies (credibility, transferability, consistency and confirmability) to confirm trustworthiness according to Guba (1981) are described according to the criteria applicable to this research:

- **Credibility**: Credibility is based on the assumption of the truth value implicating a single, tangible reality, when exposed to the most stringent of tests to confirm internal validity, is the findings of isomorphism. The concept of isomorphism is in principle impossible, the researcher should be aware of the tangible reality and therefore it does not require examination. Threats towards the internal validity should therefore be eliminated (Lincoln & Guba, 1985: 294-295).

The implementation of the credibility criterion instead of internal validity encompasses the following:

✪ The execution of the study in such a way that it heightens the possibility that findings are truthful;
✪ The demonstration of the truth value of the findings through the consent of the respondents (Lincoln & Guba, 1985: 296)

Techniques and activities to heighten the credibility are prolonged involvement, continued observation and triangulation:

✹ Prolonged involvement implies the time spent getting to know the culture, building up trust and testing of faulty information found through misinterpretation. The researcher should be accepted as part of the group. Misinterpretations should be acknowledged and handled correctly. Anonymity and confidentiality should be ensured at all times. In this research the researcher has been involved in the development and implementation of the physiotherapy practice accreditation programme for seven years.

✹ The aim of continuous observation is to identify elements and characteristics regarding the problem. The researcher should be able to distinguish between the relevant and the irrelevant. The researcher should also be able to recognise the relevant atypical elements and characteristics. The researcher should continuously describe and explore the process.

✹ Triangulation is the third method of increasing credibility or truth value. There are four methods of triangulation, namely sources, methods, researchers and theories. Sources are people that can verify data. Methods of triangulation comprises two or more measuring processes. Triangulation by means of data collecting methods can represent different data collecting processes (interviews, questionnaires, observation and testing) of different designs.

In this research triangulation took place in the following manner:

✯ A literature research to ensure empirical indicators and structure and description of the evaluation process.
✯ Evaluation of the empirical indicators for the physiotherapy practice accreditation programme by experts on the implementation of the programme.

Finally, the different theories with regard to triangulation are not acceptable to the researcher. Facts are proven through theory. When two facts are proven in two different theories, it may largely be attributed to the similarity of the theories, rather than empirical proof (Lincoln & Guba, 1985: 296-297).

✻ Debriefing is the process that keeps the researcher honest. Questions regarding the method, ethical and legal aspects are asked. Secondly, it aids in the provision of research opportunities in order to test hypotheses of which the researcher is unsure. Debriefing also provides the opportunity to develop further steps in the research method. Finally, debriefing provides the opportunity to purify the cognitive aspects. Respondents have the opportunity to question the researcher about the implications of the method, legal and ethical aspects of the research, before the questionnaires are completed.

* Negative case analysis can be described as a process of revising a hypothesis with retro-vision. The aim is the refining of the hypothesis until all cases are cleared up. Negative comments from respondents are analysed and remediated.

* References could include videotape recordings. This method has the disadvantage as raw data that it cannot readily be incorporated into a written report and needs storage space.

* Peer review is one of the most important methods to prove credibility. Marking can take place any time in a formal or informal manner. This method can be implemented consciously, mistakes can be rectified immediately, additional information can be added, respondents comments are recorded, there is opportunity for a summary and respondents have the opportunity to assess the effectiveness of the input.

This peer review by members is a more acceptable method for establishing credibility. It can however, cause a problem if the members cannot reach consensus.

- **Transferability** of a research is underwritten by a "thick" description. Qualitative research can be evaluated systematically if criteria and procedures are explicitly stated. A detailed account of the context of the research with a thorough description of all the procedures from start to finish should be described. Any reader should be able to follow all the steps in a logical manner. The researcher starts with assumptions and values that may have influenced the research. The researcher should then describe, explain and verify the study (Guba, 1981: 218-221).

- **Dependability** is described by Guba (1981) as:

  - Demonstration of techniques of validity;
  - Overlap methods is a triangulation method for truth value and not validity;
  - Step replication requires a research team of at least two persons in at least two teams. These teams will analyse the data separately; and
  - The audit examines the process and the product for accuracy.

- **Confirmability** is underwritten by the process and the process audit. Triangulation and the keeping of a reflexive journal are useful in the process of confirmability. The audit trail is the forerunner of the audit enquiry. Raw data form part of the audit trail and the audit process (Lincoln & Guba, 1985: 319). This audit trail (chain of proof) should be available.

Table 3.7. gives a summary of the trustworthiness strategies of Guba (1981: 317) and Lincoln and Guba (1985) as used in this research.

Table 3.7. Trustworthiness Strategies (Lincoln & Guba, 1985; Guba, 1981)

Strategy	Criteria	Application
Credibility / Truth Value	Experience in practice	• Researcher's experience • Practice experts
	Triangulation	• Literature research • Practice experts
	References	• Literature Research
Transferability	Sampling	• Practice experts
	Complete description	• Empirical indicators used in the process of evaluation • Evaluation of the physiotherapy practice accreditation programme
Dependability / Consistency	Audit	• Practice experts
	Description	• Empirical indicators used in the process of evaluation • Evaluation of the physiotherapy practice accreditation programme
	Triangulation	• Literature research • Experts
Confirmability	Evaluation	• Experts
	Triangulation	• Recommendations

3.3.2.5.iii.d. Population and Sample

The New Oxford Dictionary of English (1998: 1443) defines a population in research terms as "a finite or infinite collection of items under consideration". A sample (Pearsall, 1998: 1644) is defined as "a portion drawn from a population, the study of which is intended to lead to statistical estimates of the attributes of the whole population". Merriam (1998: 60) states that there are two kinds of sampling, namely, probability and non-probability sampling. Probability sampling (random sampling being the most familiar example) allows the researcher to generalise results of the study from the sample to the population from which it was drawn. Since generalisation in statistical terms is not an aim of qualitative research, probability sampling is not necessary or even justified in qualitative research. Non-probability sampling is therefore the method of choice in qualitative research. Anthropologists have long maintained that non-probability sampling methods "are logical as long as the fieldworker expects mainly to use his data not to answer questions like 'how much' and 'how often' but to solve qualitative problems, such as discovering what occurs, the implications of what occurs and the relationships linking occurrences" (Honigmann, 1982: 84). The most appropriate sampling strategy is thus the non-probability method, the most common form of which is called *purposive* (Chein, 1981) or *purposeful* (Patton, 1990: 168). Purposeful sampling is based on the assumption that the researcher wants to discover, understand and gain insight. A sample from which most can be learned must therefore be selected. Patton (1990: 169) argues that "the logic and power of purposeful sampling lies in selecting information-rich cases for in-depth study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term *purposeful* sampling". Fowler (1988) describes a *stratified* sample as a sample that reflects the true characteristics of the population and that the specific characteristics are represented in the sample.

The literature research was the first population used in this research (see Table 3.8). This was a representative, comprehensive and saturated sample researched from June 1998 to June 2001.

Table 3.8. Overview of the Literature

Foundations of Professional Physiotherapy	Legislation	Outcomes-based Education (OBE)	Quality Improvement & Accreditation
Muller (1996a, 1998, 1999) Pearsall (1998) University of Cape Town (unpublished curriculum) University of Durban Westville (unpublished curriculum) University of the Free State (unpublished curriculum) University of Pretoria (unpublished curriculum) University of Stellenbosch (unpublished curriculum) University of the Western Cape (unpublished curriculum) University of the Witwatersrand (unpublished curriculum)	Department of Education (1997a & b) Clarke (1997) Cosser (1998a & b) French (1998) Gunthorp (1998a & b) Human Science Research Council (1995) Lewis (1999) Malan (1997) Mathews (1997) Republic of South Africa (1974, 1975, 1978, 1993a & b, 1995, 1997a & b, 1998a & b, 1999) Olivier (1998) Philips (1997 a & b) SAQA (1995,1999, 2000) Vestal (1995)	Brandt (1992 & 1993) Hersey, Blanchard & Johnson (1996) Killen (1999) King & Evans (1991) Malan (1997) Olivier (1998) Spady (1994, 1996a,b,c & d) Van der Horst & MacDonald (1997) Wallace (1997)	Abruzzese (1992) Affara & Styles (1991) APIC (2000) Astroo, van der Merwe & Muller (1996) Australian Physiotherapy Association (n.d.) Accreditation Manual (1997) Bonsingl (1992, 1996) Brown (1985) Carey & Lloyd (2001) Coetzee & Muller (1995) Crosby (1984) Deming (1986) Devargas (1995) Donabedian (1986) Douglass & Bevis (1983) Duke University Hospital (1983) Evans & Lindsay (1996) Gillies (1989) Green (1994) Hadgraft & Holecek (1994) ICN (1989) JCAHO (1998) Koch & Fairly (1993) Marelli (1993) Mason (1994) Muller (1996 a& b, 1998) Oakland (1989) O'Leary (1991) Paine, Turner & Pryke (1992) Pearsall (1998) Pearse (1997) PhysioFocus (1998) Pike & Barnes (1996) Soarez (1992) Swansburg (1995) University of Maryland (1991) Van der Merwe (1994) Van der Merwe (1996) Vestal (1995) Walton (1989) West-Burnham (1992) WHO (1983) Yoder-Wise (1999)

The second population consisted of physiotherapists in private practice in South Africa. The research was limited to physiotherapists in private practice in South Africa according to the following criteria:

- Registered with the Health Professionals Council of South Africa.
- A fully paid up member of the South African Physiotherapy Society.
- A fully paid up member of PhysioFocus, the Private Practitioners Association of South Africa.
- PhysioFocus members that have endeavoured to implement the provisional PhysioFocus practice accreditation programme.

All physiotherapists involved in the implementation of the PhysioFocus practice accreditation programme were requested to complete the questionnaire. The second sample is thus a purposeful group of physiotherapists willing and knowledgeable to participate in the study.

3.3.2.5.iv. Implementation

Practical implementation of the research for the physiotherapy private practice accreditation programme was done in twelve private practices in the Western Cape. After successful implementation in the Western Cape, principals of private physiotherapy practices throughout the country were invited to partake in the programme. Interested private practitioners were issued with a practice accreditation manual, and a work book to facilitate implementation of the process. This implementation of the programme took approximately six to nine months to complete from June 1999 to March 2000. After implementation of the programme, practitioners were requested to complete and return the questionnaire on the evaluation of the physiotherapy practice accreditation programme. Thirty nine physiotherapists returned the questionnaires. These were the physiotherapists that had fully implemented the PhysioFocus practice accreditation programme in their practices.

3.3.2.5.v. Conceptualisation

Concepts utilised in evaluation of the physiotherapy practice accreditation programme was based on the literature research, AL Model and the researcher's own experience (see section 2.3).

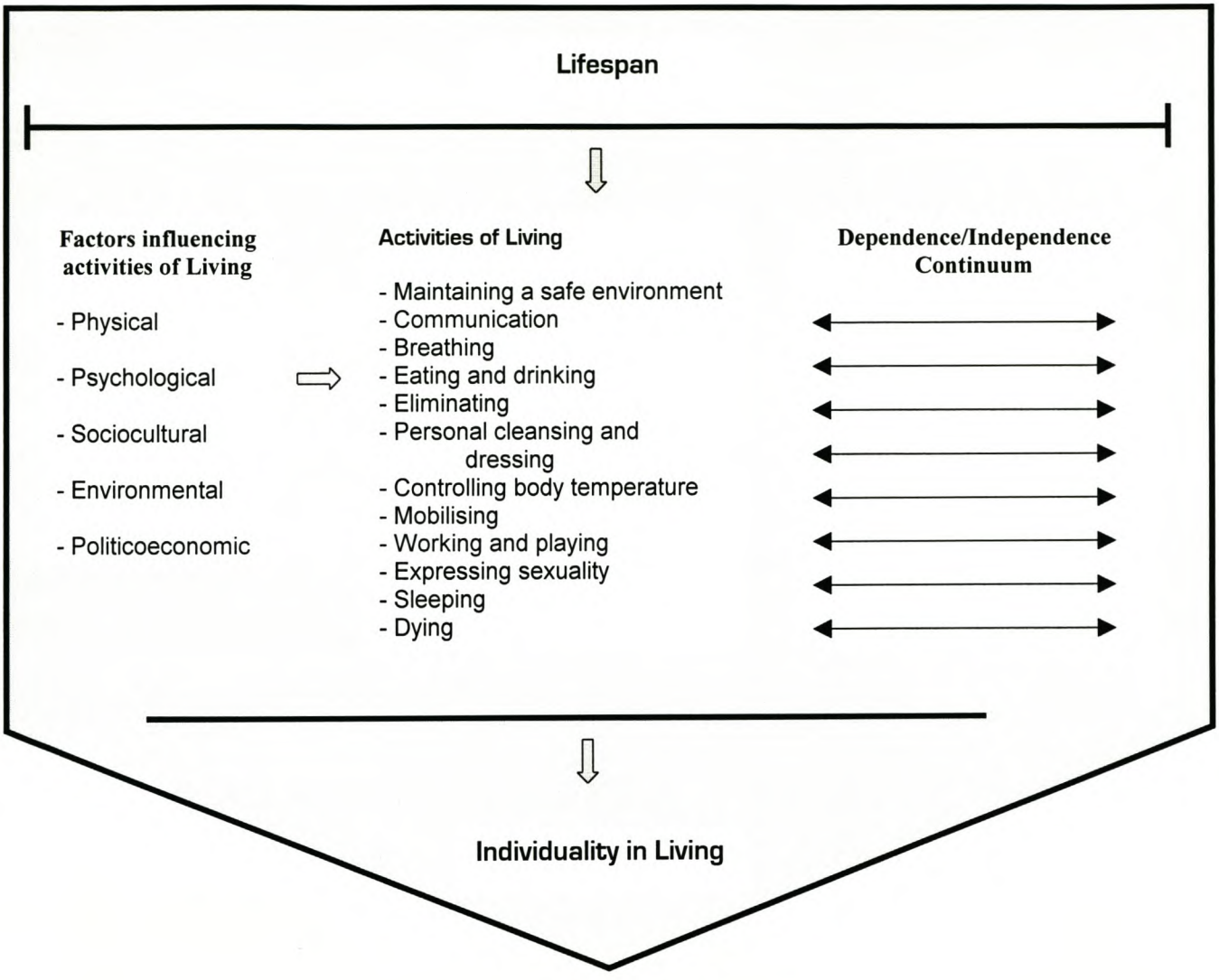
3.3.3. Third Order – Paradigmatic Perspective of the Research

The third order consists of the following:

- Meta-theoretical: This is described as part of sections 2.3.1. and 3.3.2.4.
- Methodological perspective: This is described in section 3.3.2.4.
- Theoretical perspective: Activities of Living Model (Roper et al, 2000) (See figure 3.2.). The conceptual framework for the study was based on the Model of Activities of Living (Roper et al., 2000; Pearson et al., 1996), the researcher's experience and the literature research. The researcher's experience and the literature research were described in Chapter two.

The Activities of Living model for nursing and health was developed from the Model of Living (figure 3.2.) by Roper et al. (2000). This model was chosen for this research for its clarity as well as its adaptability to physiotherapy, as it focuses on factors that influence 'activities of living' and the individualisation of care. This model focuses on the person as an individual as she takes part in living throughout her lifespan, moving from dependence to independence, according to age, circumstances and environment (Pearson et al., 1996). One of the factors influencing the quality of physiotherapy care, is the all encompassing (holistic) assessment of the patient. The patient is after all the focus of the physiotherapy treatment and therefore also the focus of the accreditation programme. The Activities of Living Model is thus an informal checklist for the evaluation instrument to be utilised in the PhysioFocus practice accreditation programme.

Figure 3.2. Model of Living (Roper et al., 2000; Pearson et al., 1996)



3.3.3.1. Components of the model

In Figure 3.2. five components of the model are identified, namely:

- Activities of Living (AL's)
- Lifespan
- Dependence/independence continuum
- Factors influencing AL's and
- Individuality in living.

Each of these factors are described in turn.

3.3.3.1.i Activities of Living

These are the 12 activities that collectively contribute to the complex process of living (see Figure 3.2). These AL's are:

- Maintaining a safe environment: People are engaged daily in activities to maintain a safe environment. This could be at home, work, play and travel. In order to maintain both public and personal health, a lot of effort has to be directed to keep the environment safe, not only for the present inhabitants, but also for future generations. Although a vast number of people live without constant threat to their environment, there are powerful natural forces (earthquakes, floods and devastating forest fires) that cannot be controlled by constantly updated new technology. Conversely, threats have also been caused by the advancement in technology, such as radiation, chemical waste, illegal drug abuse and modern warfare. Vast numbers of professionals, employers and officials are involved in keeping the environment safe. It is, however also important that every individual accepts the responsibility for their own safety (Roper et al., 2000: 16-18). The legislation as identified in Table 2.22. guides the physiotherapist in creating a safe environment for staff and patients.

- Communication: Humans are essentially social beings and most people spent the majority of their time communication with others. Communication is part of human relationships and all human behaviour. Communication takes place via verbal (the spoken word) and non-verbal (paralanguage and kinetics) communication. Often both ways are used simultaneously. Currently non-verbal communication or body language is receiving more attention. Non-verbal communication serves a number of purposes, depending on the context – the whole body may be conveying a message. Humans use their bodies to express themselves, such as the way they walk, facial expressions, hand movements and touch. Considerable cultural differences are related to touching and the user of touch as a form of communication should be sensitive to these

differences. This is an important factor in physiotherapy treatment as a large part of the treatment is "hands-on".

Communication is influenced by several factors, namely age (babies, mental condition, physical disabilities and learning difficulties), body structure (impairment of sight, hearing, smell or taste), level of intelligence, current mood (excitement, depression, level of self-esteem and concept of body image) and social and cultural values (miscommunication due to racial or ethnic differences). Communication is a complex issue and also a highly individual activity. To truly understand communication, one has to understand how people relate to each other (Roper et al., 2000: 19-22). Written communication found in patient treatment records, as well as in effective staff maintenance (minutes of meetings and communications board) facilitates quality physiotherapy delivery.

• Breathing: The first breath a newborn baby takes determines whether the baby will have a viable existence as a human being. After that breathing, in the absence of specific pathology, becomes effortless and people are almost unaware of breathing. Potential hazards to adverse breathing include tobacco smoke, pollution and pathogens. Physiotherapists play an important role in the rehabilitation and maintenance of chest conditions. A large portion of the therapy is to re-educate and improve correct breathing patterns. The WHO is monitoring and studying the problem of atmospheric pollution and the effect of pollution on breathing. All the AL's are entirely dependant on breathing (Roper et al., 2000:22-25). Ventilation principles of the physiotherapy practice must meet the standards of the South African Bureau of Standards. An effective infection control programme outlines the basics of air pollution, thus protecting both staff and patients.

• Eating and drinking: Eating and drinking play a major part in the everyday living of all age groups. It is mostly a pleasurable experience, but is essential to existence. The human body is a highly complex system, comprising of many million cells. For cell activity, growth and maintenance as well as cell repair, an energy source is required. This energy is derived from the food and liquid

intake. There are intellectual and emotional as well as sociocultural variations to food and liquid intake. It is important to coordinate staff tea and lunch breaks in such a manner that quality physiotherapy delivery is facilitated in the practice.

Currently health professionals, government agencies and the media are putting great effort into health education and particularly healthy eating habits. This impacts on the rehabilitation programmes implemented as part of physiotherapy treatment, particularly in the cases of spinal, cardiac and chest conditions. Malnutrition and the lack of safe water is still a major problem in South Africa. This education further extends to the hygienic preparation of food, storage and proper waste disposal (Roper et al., 2000: 25-28).

• Eliminating: Eliminating is an activity that all individuals perform with unfailing regularity throughout life. Eliminating is an integral part of life and also private. This is the way the body disposes of the waste product from metabolic processes. In order to eliminate in the normal way, an individual needs fully functional urinary and defaecatory systems. Modern sanitation provides the hygienic way of disposing of the waste products, leading to minimising possible contamination and spreading of infections. Physiotherapists come into contact with bodily waste products on a daily basis. The Human Tissue Act regulates the handling of bodily waste products. (Roper et al., 2000: 28-31). The provision of hygienic toilet and washing facilities in the physiotherapy practice is a fundamental element in an effective infection control programme, preventing contamination and spreading of infections and diseases.

• Personal cleansing and dressing: The ever increasing advertising of fashion, cosmetic and hair industries has increased most people's interest in personal grooming. The objective in most cultures is to teach children independent cleansing and dressing as early in their lives as possible.

Many activities are associated with daily hygiene, with hand washing the most important. The lack of hand washing is undoubtedly the main activity associated with spreading of infection in the home, at work, recreational activities and in

clinics and hospitals. This forms part of the infection control activities in a physiotherapy practice.

Dressing changes with different traditions and in different cultures. Most people dress to suit the current environment and social condition. Dressing is also a way of non-verbal communication. Appropriate clothing reduces the strain on the thermo-regulatory system of the body by protecting against wind, rain, cold, heat and the sun. It is also used in protection from injury (hard hats on building site, gloves in a cold working environment).

The ability of an individual to cleanse and dress him/herself depends on their level of physical ability. People who are physically disabled (i.e. a quadriplegic) are not able to participate in this AL. (Roper et al., 2000: 31-34).

• Controlling body temperature: For most of the time individuals are unaware of their body temperature as it remains constant at a comfortable level. This function is regulated by the hypothalamus in the brain. The hypothalamus balances the amount of heat produced and lost in the body. This balance is paramount as most of the biochemical processes that take place in the body can only take place if the body temperature remains constant in a narrow range. Factors that influence thermoregulation include food intake, social drugs, exercise, emotion, hormone levels, sociocultural norms and economic status. The individual has undoubtedly some control over thermoregulation, but the body's internal adaptation is crucial in the control of body temperature. It is of paramount importance that the physiotherapy treatment environment does not change the function of the body temperature control mechanism (Roper et al., 2000: 34-38). It is imperative that the patient is appropriately covered during physiotherapy treatment, not only for maintaining body temperature, but also for patient privacy.

• Mobilising: Body movement is a characteristic of all living things and a much valued human activity. Everyday communication is almost impossible without movement, involving the acts of speaking and listening, eye movements, facial expression and body language. Behaviour associated with the activities of

breathing, eating, drinking, eliminating, working and playing also involve movement. Whilst sleeping, the body systems continue their ceaseless activity.

Physical activity is a basic human drive and it is important throughout life. It is the capacity for movement that first allows infants to explore themselves and their environment. If a child's movement is restricted it may not only lead to impairment of physical growth, but also psychological growth. The acquisition of mobilising skills is a very complex and lengthy process.

Knowledge of the musculoskeletal system and body biomechanics is essential when analysing mobilising skills. This knowledge is applied when to apply effective techniques of mobilising and of moving and handling loads, without compromising the musculoskeletal system of the operator or the patient. The largest component of physiotherapy practice activities is concerned with the musculoskeletal system and most of the treatment involves mobilising the patient.

Threats to mobilising skills include fractures or diseased bones, diseased joints, any form of paralysis, paraplegia or nervous system failure. Positive coping mechanisms can offset individual problems with the AL's of mobilising (Roper et al., 2000: 38-41).

• Working and playing: Generally speaking most people spend one third of their day sleeping, the other two thirds, working and playing. Work and play are complementary and both are fundamental aspects of living. Both these activities have many dimensions. Depending on the stage of the lifespan, their nature and purpose are open to various interpretations.

Work tends to be thought of as gainful employment and describe an individual's main daily activity. Work does not only provide an income, but is an important part of a person's identity. Work provides a sense of purpose and accomplishment, structure to each day, a source of company and a defined status in the family and society. Physiotherapists are bound by the Health Act to

restore the patient's health to an optimal functional level as soon and effectively as possible.

Playing is the term to describe what a person does in 'non-work' time. This could take the form of sport, hobbies, recreation, exercise, holiday and relaxation. Physiotherapists are involved in sports medicine and form a vital part of the management of any sports team or sporting event. Physiotherapists are also often part of the medical team at recreational events. Enjoyment and occupation of time is the main objective in all forms of playing. For children playing is also a means of learning, exploring and developing (Roper et al., 2000: 41-44). Often physiotherapy treatment consists of play therapy, especially when dealing with children with developmental problems.

- Expressing sexuality: Identification of a newborn's sex is almost instantaneous. Sexuality is a significant dimension of personality and interpersonal behaviour throughout the entire lifespan of an individual. The ways in which sexuality is expressed may vary from culture to culture, but in any society males and females tend to show differentiation in various ways, such as dress and different roles socially and domestically. The AL of sexuality is a vast and complex dimension of living (Roper et al., 2000: 44-46). Respect for the patients' sexuality is facilitated in the physiotherapy practice by appropriate covering during physiotherapy treatment.

- Sleeping: In terms of time alone, sleep is a very important AL. Sleep provides the greatest degree of rest, although the bodily processes still continue at a reduced level. Sleep is described as a recurrent state of unresponsiveness, a state in which a person does not respond overtly to what is going on around him. Whilst sleeping, consciousness is lost temporarily, but sufficient stimulus will waken the person. Sleeping is thus quite different from the states of anaesthesia or a coma. Sleeping is often taken for granted, but there are many circumstances that can affect an individual's ability to sleep, such as musculoskeletal pain. Physiotherapists treat these conditions to alleviate pain and promote comfort. In certain cases, physiotherapists also offer relaxation therapy (Roper et al., 2000: 47-51).

• Dying: Dying is the final act of living. To die suddenly from natural causes at an old age (and without the loss of dignity) would be considered by many as a "good death". Death is often preceded by a period of survival in a state of terminal illness. This period can often be prolonged and accompanied by pain, distress and incapability to perform certain AL's. Physiotherapists often assist in the treatment of terminally ill patients, where the aim of treatment is relieving the symptoms (Roper et al., 2000: 51-55).

The term 'Activity of Living' is used in an all-encompassing (holistic) way, although each activity has many dimensions and complexities. It could be seen as an overall activity encompassing a number of specific activities that are very closely related to one another. All the AL's are important, although some take priority, such as breathing. The order in which the AL's are listed does not reflect the order of priority, as these change during various stages of the lifespan of a person. In their own right, each of the AL components contributes to another dimension of living. The implementation of a professional-ethical-legal framework in physiotherapy practice ensures the facilitation of these activities of living.

3.3.3.1.ii. Lifespan

Living is concerned with the individual's whole life. Lifespan is relevant to the whole of a person's life as it concerns a person's life from conception to death. The stage in the lifespan – infancy, childhood, adolescence, adulthood, senior citizenship – influences the individual's behaviour for each AL. The lifespan is represented in figure 3.2 by an arrowed line, indicating the unidirectional movement from birth to death. Not all people live through all the stages of life, some die at birth, some otherwise healthy people die prematurely as result of accident or disease. So, although all people have a lifespan from birth to death, the length may vary.

The collection of data about birth, death and the causes of death provide a picture of the health of the population. These statistics are used to predict the life expectancy of a given population, infant mortality rates can be used to

compare health services in different countries, the age range of people dying of a particular disease, or the statistics regarding road traffic accidents can guide the activities of health learning programmes as well as prevention strategies. This data collection also supplies information regarding employment, average retirement age, redundancy, unemployment and thus eligibility for a state pension.

As a person moves through the lifespan there is continuous change and every aspect of living is influenced by the physical, psychological, sociocultural, environmental and politicoeconomic occurrences encountered throughout life. At different stages of the lifespan there are varying degrees of dependence and independence in the activities of living (Roper et al., 2000: 55-57). Physiotherapists assess, plans, implement and document treatment regimens for each patient, according to the stage of the lifespan.

3.3.3.1.iii. Dependence/Independence Continuum

This component of the model is very closely related to the lifespan and all the AL's. There are stages in the lifespan where the individual cannot yet, or can no

longer perform certain AL's independently. It is said that each person has a dependence/independence continuum for each AL. In figure 3.2. the dependence/independence continuum is represented by a line and arrow indicating that movement can take place in any direction on the continuum, depending on the circumstances. Independence is defined as the ability to achieve the activities of living to a personal and social acceptable standard without help. From collected data there are statistical averages for the age at which independence is achieved for each AL.

Change in the dependence/independence status for one AL can cause a change in status in one or more AL's because they are so closely related. The dependence/independence status of a person in relation to AL's is not only linked to lifespan, but it is also closely linked to the factors which influence AL's

(Roper et al., 2000: 57-59). A physiotherapy regimen specific to a patient is based on this dependence/independence continuum.

3.3.3.1.iv. Factors Influencing Activities of Living

Each individual carry out AL's in a variety of ways, at whatever stage of their lifespan, as well as with differing degrees of independence. These differences occur because of the variety of factors that influence the way a person carries out AL's. These factors are:

• Biological: For the purpose of this model, biological refers to the anatomical and physiological performance of the human body. This is partly determined by the individual's genetic inheritance. There have been great advances in the study of human genetics and has aided scientists in many ways, namely, a complete understanding of the molecular structure of the human body; what goes wrong when disease interferes with normal functioning of the body; and provide pharmaceutical companies with new therapeutic targets.

• Psychological: This cannot be considered in isolation, because it relates to the other factors. It influences an individual throughout the lifespan, especially intellectual and emotional factors.

• Socio cultural: For the purposes of the model of living, the term socio cultural assumes spiritual, religious and ethnic aspects of living. These are related to the other four factors, as well as the other components of the model. They influence an individual throughout the lifespan and have an effect on the level of independence. They influence a person's individuality in living and therefore affect the way each person carries out the AL's.

• Environmental: The environmental factors differ from the other four factors represented in the model in that environmental factors do not fall into the knowledge base associated with recognised disciplines such as biology, psychology, sociology and politics. In this context it is considered to include all that is physically external to each individual. These include in the atmosphere

light and sound waves; and organic and inorganic particles, such as dust and pathogens. Also included in the environment is the natural habitat, namely local vegetation and related climate. The built environment can also influence several AL's. They need to be hazard free to enable occupants to practice the AL of maintaining a safe environment. The ventilation in the building should be adequate to ensure body temperature control. Environmental factors cannot be discussed in isolation, they are linked to politicoeconomic factors.

• Politicoeconomic: In the model of living, the politicoeconomic factors assume aspects of living that have a legal connection. Frequently political and/or economic pressure and action is reflected in legislation. Some of these are: the state, the law and the economy, the influence of the state, the influence of the individual on the state, the welfare state and the interdependence of states. It is thus imperative for the physiotherapist to have the knowledge regarding relevant legislation, pertaining specifically to physiotherapy practice in South Africa.

These factors, the AL's, the lifespan and the independence/independence continuum are interlinked. The five factors mentioned above are also interlinked with each other (Roper et al., 2000: 59-75).

3.3.3.1.v. Individuality in Living

Each individual will be affected by a distinctive range of influencing factors, the result of which will manifest itself in the way the individual lives. Each person's individuality in carrying out AL's is, in part, determined by the stage on the lifespan, degree of dependence/independence. and is further moulded by the impact of a variety of factors, namely, physical, psychological, sociocultural, environmental and politicoeconomic factors. Individuality of living is a product of all the other four components (see figure 3.2.).

A person's individuality can manifest itself in many different ways:

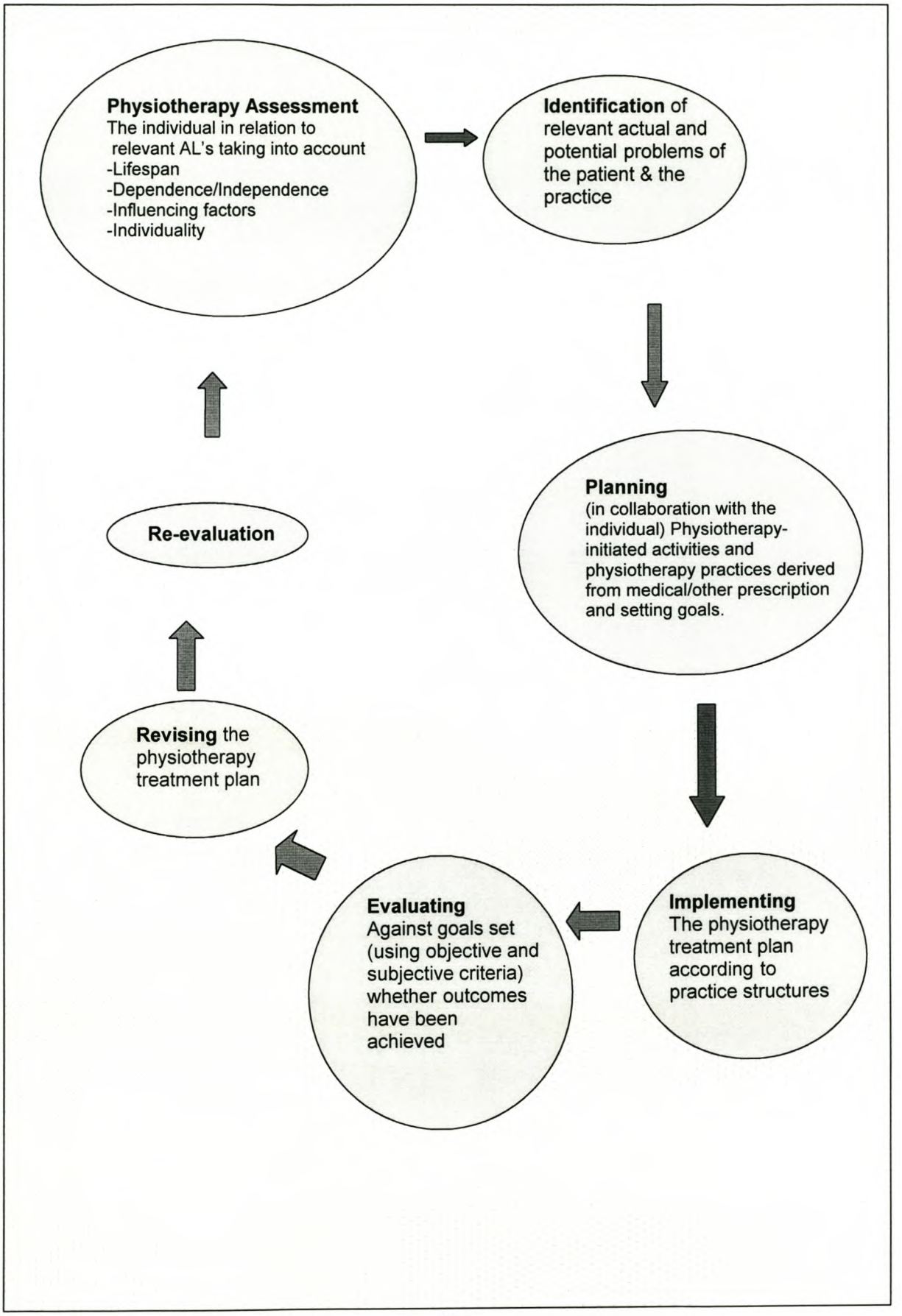
- How a person carries out the AL;
- How often the person carries out the AL;
- Where the person carries out the AL;
- When the person carries out the AL;
- Why the person carries out the AL;
- What the person knows about the AL
- What the person believes about the AL; and
- The attitude the person has towards the AL.

The concept of individuality of living is a product of the other concepts in the model and is clearly depicted in figure 3.2. The other four concepts join to produce an unique mix that determines individuality (Roper et al., 2000: 75-76).

Although the model refers to individuals, it can also be used in the context of families or larger groupings of the community. This conceptual model is not intended to be inflexible or limiting – it is a tool to assist understanding. The model uses broad concepts that can have wide application. All treatments rendered by physiotherapists are individualised.

This model will provide the conceptual framework in the assessment, planning, intervention and evaluation of the physiotherapy practice accreditation programme. See figure 3.3. for a model of physiotherapy based on the model of living (Roper et al., 2000).

Figure 3.3. The researcher's scientific implementation of the ALM in physiotherapy practice



3.4. SUMMARY

In Chapter three the research design and research methodology was described according to the Botes Research Model (1998, 2000).

Qualitative researcher's act according to history, interactions and structures. These researchers seek to examine the major public and private issues and personal troubles that define a particular moment in time. Qualitative researchers draw upon their own experiences as a resource in their inquiries. The search for strategies of empirical inquiry that will allow them to make connections among lived experience; larger social and cultural structures; and the here and now. These connections are forged out of empirical materials that are gathered in any given investigation. Empirical inquiry is shaped by paradigm commitments and by the recurring questions that any given paradigm, or interpretive perspective, enquires about human experience (Denzin & Lincoln, 1998b: xi; 1998c: 195).

The data collection and data analysis is described in Chapter four.

Chapter Four

Data Collection, Analysis and Results

The true goal is not to reach the uttermost limits, but to discover a completeness that knows no boundaries - RABINDRANATH TAGORE (Stray Birds, 1916).

4.1. INTRODUCTION

The conceptual framework for the evaluation of an accreditation programme for quality improvement in private physiotherapy practice in South Africa was described in Chapters one (see section 1.3.3) and three (see section 3.3.3). In this chapter the operationalisation and evaluation of the PhysioFocus practice accreditation programme is described. Evaluation of the accreditation programme was according to the central theoretical assumption of the researcher. This was conducted by means of an open-ended questionnaire completed by physiotherapists in private practice that met the sample criteria. The data collection, analysis and interpretation were conducted simultaneously. Selected actions in steps one to five of the FOCUS-PDSA Model research process were implemented and described in this chapter.

Strategies of reasoning implemented in this Chapter are analysis, deduction, derivation and synthesis. These strategies were implemented in the analysis of the data resulting from the questionnaire to evaluate whether the central theoretical assumption was supported by the results.

4.2. CENTRAL THEORETICAL ASSUMPTION OF THE RESEARCH

The evaluation of the accreditation learning programme for quality improvement in private physiotherapy practice in South Africa should facilitate:

- quality physiotherapy practice;
- professional and personal development;
- monitoring of the progress of the pre- and post accreditation process; and
- monitoring and remediation of continuous changes in private physiotherapy practice (see section 1.2.2.).

4.3. DEFINITIONS

The definitions applicable to the context of this chapter are the following:

4.3.1. Quality physiotherapy practice: The implementation and monitoring of the PhysioFocus practice accreditation programme for quality improvement in private physiotherapy practice.

4.3.2. Professional and personal development: This implies the internalised and applied knowledge of physiotherapists regarding the PhysioFocus practice accreditation programme.

4.3.3. Monitoring of the progress of the pre- and post accreditation process: The implementation of an open-ended questionnaire.

4.3.4. Monitoring and remediation of continuous changes in private physiotherapy practice: This is achieved by the implementation of a validated checklist.

4.4. OBJECTIVES OF THIS CHAPTER

The objectives of this chapter is to describe the following:

- the operationalisation of the PhysioFocus practice accreditation programme;
- the evaluation of the learning programme for the PhysioFocus practice accreditation programme in order to identify remedial actions to be iplemented (phase two of the research objectives); and
- the evaluation of the PhysioFocus practice accreditation programme (phase three of the research objectives).

4.4.1. The Operationalisation of the PhysioFocus Practice Accreditation Programme

The operationalisation of the PhysioFocus practice accreditation programme is described according to the structure and the process of the accreditation programme.

4.4.1.1. Structure of the PhysioFocus Practice Accreditation Programme

The PhysioFocus practice accreditation programme was published by PhysioFocus in 1998 under copyright. The programme may therefore not be included as an Appendix. The PhysioFocus practice accreditation programme is summarised in the following sections.

The PhysioFocus practice accreditation programme manual contains the following:

- a letter of information from the national accreditation chairman on the contents of the manual as a tool to prepare for practice accreditation;
- a foreword by the national chairman of PhysioFocus, the Private Practitioners Association of the South African Society of Physiotherapy; and
- a PhysioFocus practice accreditation programme mission statement including a reason for the PhysioFocus practice accreditation programme, with an integrated system to inspire the highest standards of service delivery;
- The five standards contained in the PhysioFocus Practice Accreditation Programme manual (see section 4.4.1.1.ii.).

4.4.1.1.i. Introduction to the PhysioFocus Practice Accreditation Programme Manual

The introduction is summarised in Table 4.1. and Figure 4.1. depicts the researcher's view of the key elements of accreditation.

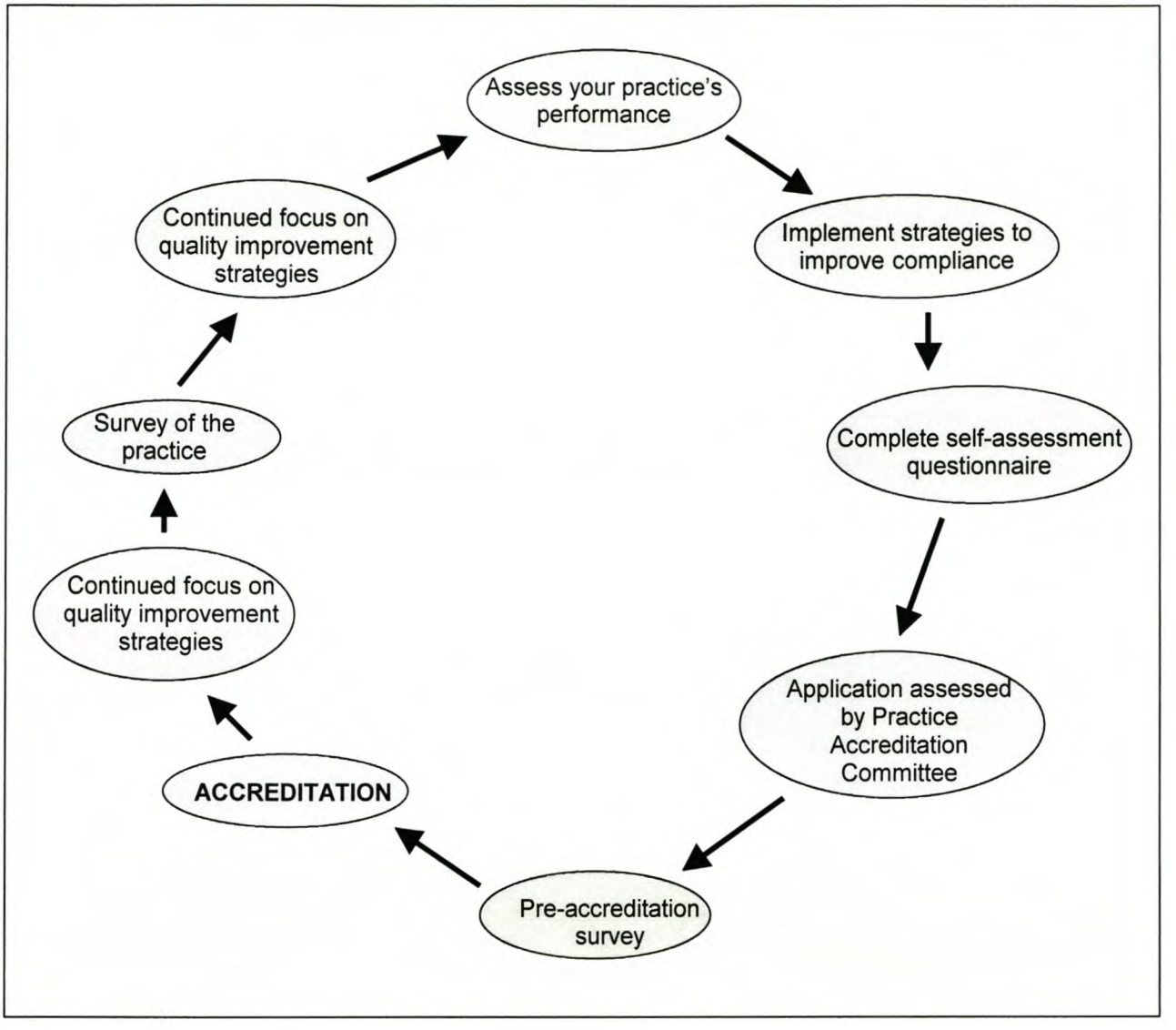
Table 4.1. Introduction to the PhysioFocus Practice Accreditation Programme Manual

Topic	Summary
• Using the manual	• Explains the basis of the standards, glossary and application form.
• Benefits of accreditation	• Gives private practitioners due recognition for meeting high standards in private practice.
• Important point to note	• The programme is voluntary; • All the standards are mandatory; • The standards reflect current practice; • Length of accreditation term (four years); and • Revision of standards (every two years).
•Practice accreditation personnel	• **Practice accreditation committee** responsible for: ❁ Conferring accredited status on behalf of PhysioFocus; ❁ Reviewing the Practice Accreditation Standards periodically; ❁ Appointing Provincial Accreditation Officers and Surveyors; and ❁ Reporting regularly to PhysioFocus on the status of the Practice Accreditation Programme. • **Provincial Accreditation Officers (PAO)** responsible for: ❁ Providing the link between prospective applicants, accredited practices and the accreditation committee; ❁ Promoting the PhysioFocus practice accreditation programme; and ❁ Co-ordinating education of private practitioners in relation to the programme. • **Practice Accreditation Surveyors** responsible for: ❁ Performing physical inspections of accredited practices; ❁ Establishing the validity of the application form; ❁ Ensuring that all standards are upheld; and ❁ Preparing a comprehensive report for the practice accreditation committee after a survey has been performed. • **Practice Accreditation Co-ordinator** responsible for: ❁ Liasing with the practice accreditation committee; ❁ Preliminary assessment of applications for accreditation; and ❁ Co-ordinating of surveys.
•Key elements of accreditation	See figure 4.1.
❁Assessing practice performance	• Reading the manual; • Assess performance of the practice against each standard; • Identify areas that need improvement; and • Discuss strategies for improvement with staff.
❁ Strategies to ensure compliance	• All staff should be involved in the process; and • Assistance and advice is available from the Practice accreditation committee and PhysioFocus national office.
❁ Applying for accreditation	• Completed application form; • Completed self-assessment questionnaire; • Application fee; and • Closing dates (1 April and 1 October each year).
❁ Fees	• Application fee – non-refundable; and • Continuance fee – annually for four years.

Table 4.1. Introduction to the PhysioFocus Practice Accreditation Programme Manual, cont.

Topic	Summary
❁ Assessment of application	• Application form is checked by the practice accreditation co-ordinator to ensure all documentation is present; • Applicants will be notified at this point if they are to undergo a pre-accreditation survey; • Approximately one month after closing date the practice accreditation committee meets to examine each application thoroughly. If the application complies with all the standards, accredited status is granted; • In the event of an incomplete application, further information may be requested before accredited status is granted; • If an application fails to meet any one of the standards, accreditation may be denied outright; and • Appeals may be lodged with the PhysioFocus national chairman within 30 days of accredited status being denied.
❁ Accreditation achieved	• Accredited status commences on 1 January or 1 July each year; • A certificate with period of accredited status will be issued; • Practice may state accredited practice status on stationary; • Practice name will be listed at the PhysioFocus national office; • A poster promoting accredited status will be issued to practice; • The national PhysioFocus office must be informed within 30 days of a transfer in ownership; and • In the case of a change of location, a practice must resubmit a newly completed application form and relevant fee.
❁ Continued focus on Quality improvement	• A system should be developed to review the practice's performance continually. This system must be documented, including the achievements and implementing a range of strategies aimed at evaluating current work practices and activities.
❁ Re-applications	• Accredited practices are required to re-apply for accredited status in the round prior to the completion of their accredited term (four years). Practice principles will receive notification from the PhysioFocus national office three month before re-application is due.
❁ Complaints	• Complaints against accredited practices may be made in writing to the national PhysioFocus chairman.
❁ Survey process	• Random survey of accredited practices: all accredited practices will be randomly selected for assessment by a surveyor at least once during the accredited period. A minimum of one week's notice will be given; • Pre-accreditation survey: a practice may be selected for a survey prior to accreditation. All applications are eligible for a pre-accreditation survey; • Failure to make a practice available for a survey will result in accredited status being withdrawn.

Figure 4.1. The researcher's view of key elements of the accreditation process



4.4.1.1.ii. The Standards Contained in the PhysioFocus Practice Accreditation Programme Manual

Standards on organisation and administration; staff development and administration; policies and procedures; facilities and equipment; and quality management are described in the PhysioFocus practice accreditation programme. All these standards have to be implemented in order to achieve accredited status. Tables 4.2 – 4.6. summarise the implementation of the five required standards into the individual private physiotherapy practice.

- Standard One: Organisation and Administration

Statement: The practice is organised and administered to provide optimum quality of care according to the objectives of the practice; to meet the needs of the patient population being served; and in accordance with the practice accreditation programme ethical principles, clinical standards and guidelines (see Table 4.2).

Table 4.2. Standard One: Organisation and Administration

Criteria	Interpretation
• There shall be a mission statement that describes the philosophy, parameters and scope of the service. • There shall be clearly defined practice objectives that direct the quality activities of the practice.	• The mission statement and the practice objective must be available to all staff. • There must be evidence that the mission statement has been reviewed within the last four years. • There must be evidence that the practice objectives are reviewed annually.
• The practice shall maintain a relevant and up-to-date policy and procedure manual.	• All relevant practice information must be recorded an available for use by staff.
• Where there are two or more persons working at the practice, there shall be regular communication.	• There must be documented evidence of the communication, such as agendas and minutes of staff meetings, message book and notices on the staff notice board.
• Clear and legible clinical records shall be maintained for all patients of the practice.	• The clinical record must include documentation of detailed assessment, treatment goals and plans, with informed consent and warnings given. For every patient attendance there must be a description in the clinical record of re-assessment details, treatment given and response to treatment. • Consent to treatment must be gained from the patient prior to treatment, upon change of treatment or if a change of physiotherapist occurs. This consent must be recorded in the clinical record. • All entries in the clinical record must be signed and dated by the treating physiotherapist. The physiotherapist's full initials shall prefix computerised clinical records before each field in each record. • Where appropriate, the clinical record shall show evidence of verbal or written communication with other health professionals and referrers. • Discharge information, including outcome of care provided, shall be recorded for every patient episode of care.
• Risk management strategies shall be employed to ensure adequate insurance cover for practice and staff.	• The practice must have sufficient public liability insurance. The cover should never be less than that offered by PhysioFocus. • Practice principal(s) and physiotherapy staff must have adequate malpractice/ professional indemnity insurance cover. This cover should never be less than that offered by the SASP.

Table 4.2. Standard One: Organisation and Administration, cont.

Criteria	Interpretation
• Appropriate statistical records shall be compiled monthly.	• The amount of patients treated, new patients, number of treatments per patient must be compiled.
• The practice shall have a financial statement and report prepared every year.	• The document must be available as evidence of compliance.
• An effective account management system shall be in place in the practice.	• The accounts management system should: - Produce accounts and receipts for all patients; - Incorporate a debtor management system; and - Maintain records of all income and expenditure items.

• Standard Two: Staff Development and Administration

Statement: Practice objectives are achieved through appropriate staffing and direction. Staff shall participate in appropriate educational programmes that augment their knowledge and skills to complement the practice objectives (see Table 4.3.).

Table 4.3. Standard Two – Staff Development and Administration

Criteria	Interpretation
• All practice principals shall have a minimum of two years post-graduate clinical experience.	• Evidence of date of qualification must be supplied on request.
• All physiotherapy staff shall be registered under the rules of the Health Professions Council of South Africa	• Proof of registration for all physiotherapy staff must be kept on the practice premises.
• All practice principals shall be members of PhysioFocus and the SASP.	• Copies of current SASP membership cards for all practice principals must be kept on the practice premises.
• There shall be a letter of appointment and/or contract of employment for each person employed by the practice.	• Letters of appointment or contracts of employment for all physiotherapy staff who are not SASP members must contain a clause requiring all physiotherapy staff to practice in accordance with all the practice accreditation programme ethical principles, clinical standards and guidelines.
• The practice principals shall ensure that an internal education programme that is appropriate to the practice objectives, is in place.	• There must be evidence that all health care professionals employed by the practice have participated in the internal education programme in the last 12 months.
• All health care professionals employed by the practice shall have participated in an relevant external education event in the last 12 months.	• A detailed list of external education events, including topics and dates, must be kept by all health care professionals employed by the practice.

Table 4.3. Standard Two – Staff Development and Administration, cont.

Criteria	Interpretation
• All staff (including non-clinical staff), shall be able to perform cardiopulmonary resuscitation (CPR).	• All staff must be trained in line with the recommendations of the Heart Foundation of South Africa. • There must be evidence of annual updates for all staff.

• Standard Three: Policies and Procedures

Statement: The operation of the practice complies with all practice accreditation programme ethical principles, clinical standards and guidelines and is consistent with relevant regulations and requirements of statutory authorities (see Table 4.4.).

Table 4.4. Standard Three – Policies and Procedures

Criteria	Interpretation
• All principals and physiotherapy staff shall practice in accordance with the current practice accreditation programme ethical principles.	• A copy of this document must be present in the practice. • All physiotherapy staff must be familiar with this document and must acknowledge this by signing and dating the document.
• Where applicable, all principals and physiotherapy staff shall practice in accordance with the practice accreditation programme clinical standards and guidelines.	• A copy of this document must be present in the practice. • All physiotherapy staff must be familiar with these documents and acknowledge this by signing and dating the document.
• An appropriate initial assessment shall be conducted for each new patient.	• Sufficient time must be allowed for initial assessment and treatment. • No other patient may have an appointment to see the same physiotherapist at the same time. • All hydrotherapy patients must have a land based initial assessment before commencing hydrotherapy.
• Each patient treated within the practice shall be entitled to an appropriate level of service.	• On average, no more than four individual treatments per hour should be performed by any one physiotherapist.

• Standard Four: Facilities and Equipment

Statement: Appropriate facilities and equipment are available for the efficient operation of the practice and for quality patient management (see Table 4.5.).

Table 4.5. Standard Four – Facilities and Equipment

Criteria	Interpretation
• Appropriate safety precautions shall be observed when undertaking patient treatment, in particular when using electrical and mechanical equipment.	• A warning sign pertaining to cardiac pacemakers must be prominently displayed outside the treatment areas. • A warning sign pertaining to heat treatments and electrical stimulation must be prominently displayed in all treatment areas where these modalities are used. • All patients must be questioned about the presence of any contraindication prior to the treatment application. Any such contraindication must be clearly documented in the clinical record. • All patients must have explained to them any possible inappropriate or negative responses to treatment, prior to the treatment being undertaken. Such warnings must be clearly documented in the clinical record. • All patients left unattended when receiving any physical or electrical modality must be supplied with a bell or buzzer. • Practices conducting hydrotherapy must ensure that staff involved are familiar with and competent in the hydrotherapy safety and emergency policies and procedures for the practice.
• All equipment shall be adequately maintained and replaced as necessary.	• All electromedical equipment must be tested for electrical safety and appropriate performance parameters at least every 24 months, by a suitably qualified person. • A current record of all dates when electromedical equipment is checked, calibrated and repaired, together with a detailed record from the service provider, noting results of all testing and repairs carried out to each piece of equipment in the practice, must be available.
• The environment shall be safe and ensure the comfort of patients and staff.	• All electrical outlets and wiring must be well maintained by a licensed electrician. • There must be a safe and unobstructed passageway between all service and utility areas. • There must be appropriate lighting in the treatment areas. • Ventilation in the treatment areas must be sufficient to ensure the comfort of patients and staff and the elimination of odours. • Toilet and washing facilities must ensure the comfort and hygiene of patients and staff. • The temperature in the practice must ensure the comfort of patients and staff.
• There shall be provision in the practice for patient privacy relating to clinical and personal matters.	• The treatment areas must provide an environment for visual privacy for patients (ie. curtains, doors, use of gowns). • The practice must provide facilities to enable private and confidential discussion to be held.
• The practice shall be maintained in a clean and hygienic manner, with appropriate infection control measures being taken.	• Major cleaning must be performed at least once a week, with spot cleaning when necessary. • Materials that come into contact with patients' skin must be changed or wiped in accordance with the current accreditation guidelines for infection control. • Face openings in plinths must be cleaned between patients or disposable protective tissue used for each patient. • Physiotherapy staff must wash their hands between patient contact to prevent cross infection. • Treatment electrodes that are re-used must be cleaned/disinfected between patient applications.
• All staff shall be aware of potential hazards to patients and the practice (including fire, electrocution, hydrotherapy emergency, cardiac arrest) and the action to be taken in such an emergency.	• There must be documentation of the action to be taken available to all staff.

Table 4.5. Standard Four – Facilities and Equipment, cont.

Criteria	Interpretation
• An appropriate fire extinguisher(s) shall be present in the practice and staff should be educated in its use.	• The extinguisher(s) must be appropriate for both regular and electrical fires. • The extinguisher(s) must be accesses easily by staff. • The extinguisher(s) must be serviced at least annually.

• Standard Five: Quality Management

Statement: The practice shall employ activities to apply quality management principles to the operation of the practice. These activities should relate to the practice objectives (see table 4.6.).

Table 4.6. Standard Five: Quality Management

Criterium	Interpretation
• There shall be evidence of quality activities being undertaken in the practice.	• There must be evidence of regular monitoring of practice management issues, both clinical and administrative. These activities must be thoroughly documented. or • There must be evidence of attendance of a PhysioFocus quality management workshop/seminar, or a programme of equivalent standard, in the last six months. Attendance at a quality management workshop/seminar will only be accepted as complying with this standard once, on the first occasion of application.

The manual is concluded with five Appendices of practical implementation of the standards. A workbook and checklist to initiate the preparation and implementation phases, is supplied. The workbook contains step-by step instructions for preparation and implementation. Examples of relevant forms, formats, warning signs and documentation are supplied.

4.4.1.2. Process of the Implementation of the PhysioFocus Practice Accreditation Programme

PhysioFocus identified a need for practice accreditation in 1994. The approval from the members of PhysioFocus for development and implementation of an accreditation programme was obtained at the annual general meeting of PhysioFocus. An accreditation committee was established to investigate existing physiotherapy accreditation programmes internationally, as none were in existence in South Africa. After gathering knowledge and information on various physiotherapy accreditation programmes, it was decided to approach the Australian Physiotherapy Association (APA) with a view to acquiring their existing physiotherapy accreditation programme. The decision was made because the APA practice accreditation programme was the best developed for South African health care conditions and it would have been too time consuming and costly to develop a new physiotherapy practice accreditation programme. Other programmes investigated, included the British, Dutch and New Zealand physiotherapy accreditation programmes. The APA accreditation programme was acquired in 1996.

The accreditation committee adapted the APA accreditation programme to suit the physiotherapy environment in South Africa. The accreditation committee (consisting of eight members) divided the manual into eight sections, one of which was allocated to each individual committee member. Committee members scrutinised the document for implementation in the South African physiotherapy context and suggested changes, additions or omissions. The accreditation committee held monthly meetings to consider feedback of work allocation. The main changes in the programme related to national registration and professional association guidelines, national legislation, national building, electrical and fire regulations. A South African infection control consultant validated the infection control aspects according to South African standards. The accreditation committee chairman collated and co-ordinated the activities and the adapted programme. This process was completed in 1997 at the same time as the APA upgraded their version of the practice accreditation programme. PhysioFocus decided to acquire the updated version for

incorporation in their accreditation programme. The updated PhysioFocus practice accreditation programme was ready in 1998 and implementation thereof was planned for 1999. The implementation of any accreditation programme requires surveyors to inspect the individual implementation in a given practice. The function of the surveyors is to perform physical inspection of practices (pre- or post accredited status), to establish the validity of the practice accreditation application form and ensure that all standards are upheld. Each provincial PhysioFocus group elected two surveyors to act on behalf of the practice accreditation committee in that province. In two of the provinces, Northwest and Northern Province, only one surveyor was nominated and elected, the reason being that there are less physiotherapy private practices in those two provinces than the rest of the country. Prejudice against specific physiotherapists is eliminated by the construction of the surveyor checklist as all standards are mandatory and have to be complied with in the form of physical evidence to that effect. Inclusion criteria for surveyors are according to the population sample of the research (see section 1.5.2). Following the completion of the PhysioFocus practice accreditation programme manual, guidelines for assessment procedures to be utilised by the practice surveyors were developed by the accreditation committee.

Planning for implementation of the programme included identification of national practice accreditation surveyors and ten private practices in the Western Cape. These private physiotherapy practices were mainly those of the accreditation committee members.

A pilot survey was conducted in the ten identified physiotherapy practices. An accreditation committee meeting was held to discuss identified problems, ambiguity and practical implementation. Suggested changes were implemented in the programme. These changes were implemented by the ten practitioners, after which a second survey was performed.

Informal training for the implementation of the PhysioFocus practice accreditation programme consisted of information and question-answer sessions at regional PhysioFocus meetings, as well as a workshop on the

implementation of the PhysioFocus practice accreditation programme in Gauteng during August 1999. This workshop was attended by approximately 250 PhysioFocus members.

Formal training for the 16 national surveyors of PhysioFocus practice accreditation programme was offered in Cape Town during March 2000 by the accreditation committee. This consisted of a walk-through-the-manual session, practical demonstration of a survey, as well as personally performing three surveys. The surveyors completed all the relevant documentation related to the accreditation process, followed by a debriefing session. All the surveyors concurred that the programme was ready for national implementation.

After successful implementation in the Western Cape, principals of private physiotherapy practices throughout the country were invited to participate in the programme. Interested private practitioners were issued with a practice accreditation manual, and a work book to facilitate implementation of the process. This implementation of the programme took approximately six to nine months to complete, from January 2000 to March 2001. After implementation of the programme, practitioners were requested to complete and return the questionnaire on the evaluation of the PhysioFocus practice accreditation programme.

4.4.2. The Evaluation of the Learning Programme for the PhysioFocus Practice Accreditation Programme

The evaluation of the learning programme for the PhysioFocus practice accreditation programme is described according to the central theoretical assumption (see section 4.2.).

4.4.2.1. Research Design for the Evaluation of the Learning Programme of the PhysioFocus Practice Accreditation Programme (Central Theoretical Assumption)

An exploratory, descriptive and partially explanatory design was implemented to evaluate the learning programme of the PhysioFocus practice accreditation programme. This supported the central theoretical assumption. The learning programme, as part of the PhysioFocus practice accreditation programme, resulted in quality physiotherapy practice and simultaneously also brought about professional and personal development as supported by the results of the questionnaire (see section 4.4.2.2).

4.4.2.2. The Target Population for the Evaluation of the Learning Programme of the PhysioFocus Practice Accreditation Programme (Central Theoretical Assumption)

The inclusion criteria for the target population for the evaluation of the learning programme of the PhysioFocus practice accreditation programme were as follows:

- Registered with the Health Professionals Council of South Africa.
- A fully paid up member of the South African Society of Physiotherapy.
- A fully paid up member of PhysioFocus, the Private Practitioners Association of South Africa.
- PhysioFocus members that have endeavoured to implement the provisional PhysioFocus accreditation programme.

Evaluation of the PhysioFocus practice accreditation programme was examined against the central theoretical assumption.

4.4.2.3. Data Gathering and Data Handling

The data was gathered according to a semi-structured questionnaire during April 2000 (see Appendix three) because the physiotherapists in the target population refused individual interviews, as this would mean valuable treatment time out of their practice. The questionnaire was distributed to all physiotherapists in private practice according to the criteria of the sample population (see section 1.5.2.). The researcher explained the goal of the research and gathered the data by means of eleven open-ended questions with a section for comments (see Appendix three). It took each respondent approximately 40 minutes to complete the questionnaire. To ensure trustworthiness of the responses, respondents could remain anonymous. Thirty nine respondents participated in the completion of the questionnaires. This constituted a saturated sample, as these 39 physiotherapists had implemented the PhysioFocus practice accreditation programme fully in their practices. Physiotherapists who had not completed the implementation of the PhysioFocus practice accreditation programme were not included in the final sample.

4.4.2.4. Results of the Questionnaires on the Evaluation of the Learning Programme for the PhysioFocus Practice Accreditation Programme

The responses to the open-ended questionnaire are recorded below. These responses are recorded verbatim, and the Afrikaans comments translated into English in brackets. The responses are tabulated below (see Tables 4.7 to 4.18).

Table 4.7. Question 1. What is Your Overall Impression of the Practice Accreditation Programme?

Respondent	Response
1	Die program is sinvol omdat dit diens verbeter (The programme is meaningful because it improves service).
2	Baie goed, volledig en professioneel (Very good, thorough and professional).
3	Excellent guidelines to obtain and maintain ethical and clinical standards. Time consuming.
4	Well-compiled, comprehensive. Deserves more funding and support.
5	Soos ek meer inligting en kennis van die akkreditasie program ingewin en bekom het, het my entoesiasme net toegeneem (As I acquired more information and knowledge of the accreditation programme, so my enthusiasm increased).
6	Very good in principle. Can be intimidating for solo practices.
7	Excellent. Very detailed. I believe the programme will benefit all concerned (including the patient, clinical and administrative staff) and ultimately our profession.
8	A lot more documentation for physio's, but overall an excellent programme to keep standards on a high scale.
9	Goed, net aanvanklik oorweldigend. Dit is goed want alle aspekte van praktyk bestuur word aangeraak (Good, just overwhelming in the beginning. It is good because all aspects of practice management are addressed).
10	It's excellent and very first world. In striving to attain these standards, practices will improve all aspects of administration, training , infection control, etc.
11	Good. Well thought out.
12	Constructive. Covers all aspects of physio practice.
13	Constructive and covers all important aspects.
14	Baie ure se navorsing is ingesit in die samestelling hiervan. Ons behoort al op universiteit hiervan geleer het (Many hours of research went into the compilation of the document. We should have learnt this at university).
15	No Comment.
16	Physio's in Pretoria are scared of the programme. I can see the need, reasons for it. I look forward to the day when all practices will be accredited.
17	Quite difficult to understand the reason at first, but gradually became aware of the importance as I worked with it.
18	Good, I can see a lot of hard work went into it.
19	Excellent. Very informative. It might have been shorter. The process was slow, but a very teachable and valuable experience.
20	The process is good, since you are forced to evaluate your practice continually and to then always be aware of what's best for your patients.
21	Good idea to make sure that standards are held high. Thereby one can assure uniformity amongst physio practices.
22	Very good – it is well set out and it makes you sit down and think about the systems that you run.
23	Very good general standard. Maybe too much repetition of certain instructions. Very time consuming, but worthwhile.
24	It is a good idea, seeing that it keeps the individual practices up to standard, seeing that we give our patients the best treatment and thereby promoting our profession in the community at best.
25	Good.
26	Probably the best thing to happen to physiotherapy. A voluntary system of quality control to enable us to market our products in a professional manner.
27	It is a comprehensive, well prepared manual which obviously was not put together in a hurry and in which all various aspects of the accreditation concept get extensive attention.
28	No Comment.
29	A must.

Table 4.7. Question 1. What is Your Overall Impression of the Practice Accreditation Programme? cont.

Respondent	Response
30	No comment.
31	I am very excited about it. I think it forces the practitioner to take a critical view of his/her practice.
32	It is a good, well thought through programme. It will ensure a high standard of quality without causing any doubt as to how/when/where to implement strategies.
33	Excellent.
34	It is really a mouthful. I agree that it would be a good thing.
35	Excellent in big practices. Too costly for small businesses.
36	Excellent in big practices, costly for small practices
37	Excellent guide to be used for assessing the standard of practices. Wonderful tool to use to continually raise the standards of physio practices.
38	It is very good.
39	Very well and thoroughly constructed with very much attention to detail. I would very much like to be assured that these standards are possible to maintain over a prolonged period in a busy practice.

All the respondents, except three, regarded the programme as a very good to excellent programme (three respondents did not comment). The programme was described as "meaningful, well thought-out, informative, first world, well constructed, well researched, much needed in the profession. Much mention was made about the implementation and maintenance of standards. This included improved knowledge, documentation, quality control and practice management. Many respondents expressed the view that the implementation of the accreditation programme will improve the professional image of physiotherapy. Only four respondents described the initial experience as overwhelming, scary and difficult to understand. After familiarising themselves with the content these respondents became aware of the importance of the programme and their enthusiasm increased. It appears from the above comments that the assumptions of quality physiotherapy practice and professional and personal development in the central theoretical assumption are supported.

Table 4.8. Question 2. What are the Positive Aspects of the Practice Accreditation Programme?

Respondent	Response
1	Verbeter die kwaliteit van behandeling, maak dit sinvol en doeltreffend. Klientediens word beter (It improves the quality of treatment, making it meaningful and efficient. Client service improves).
2	Dit het my beter na praktykbestuur laat kyk. Ons moes dit op universiteit geleer het (It allowed me to have a better look at practice management. We should have learnt this at university).
3	It sets a standard for private practice. It forces you to think and document well.
4	Due to the lack of sufficient management skills programmes (pre- and post grad) this programme gives incentives and opportunities to the physio to improve managerial skills.
5	As physio's in SA we desperately need standardisation in order to market ourselves adequately. Accreditation is the very logical and much needed step towards setting high standards for our profession. Standards by which we can be measured and compared with the masses out there that are not only keen to feed off the cake that should be the physio's. People who can not meet these reasonable standards, I am cocky enough to say, are probably not doing our profession a whole lot of good.
6	Verkry en behou hoë standaarde met betrekking tot 'n professionele fisioterapie diens (Acquiring and maintaining high standards with regard to a professional physiotherapy service).
7	Practice management, appearance and service will be much more professional. Continuing education will become the norm. Clinical outcomes and other statistics will be more freely available.
8	Provides detailed structure for developing a truly professional practice (practice management). Ensures continuing education and gets staff more involved in the practice.
9	Will keep standard high and very professional.
10	Werkende boek vir dag tot dag hantering van 'n praktyk (A practical book for the day to day running of a practice).
11	Will prevent practices from allowing standards to slip.
12	Enforcement of standards, constant re-evaluation by practitioner. Standardised care.
13	If adhered to would improve standard of physio generally and the physio image will be enhanced.
14	To improve the standard of physio as a profession.
15	Uniforme norm waarvolgens standaarde nasionaal neergele word. Dit is goed om te weet jy doen dit op die regte manier (Uniform norms according to which standards are laid down. It is good to know that you are doing it in the right way).
16	Due to the lack of sufficient management skills programmes (pre- and post grad) this programme gives incentives and opportunities to the physio to improve managerial skills.
17	Protects the patient from bad service. Protects the physio when in a law suit. Protects the profession from bad publicity die to bad management.
18	To set an overall improvement of standards, ie. Quality control nationwide.
19	Will improve the standard of physiotherapy in practices. Will improve record keeping.
20	It motivated me to improve my record keeping. I realised my practice's shortcomings and would like to be accredited.
21	Identifying your practice's shortfalls and to improve upon it. It keeps you on your toes.
22	Allows one to re-assess what you are doing. It highlights areas where one does have shortcomings.
23	The fact that you have a certain standard to uphold makes it worthwhile for the patient and your staff.
24	Put and keep necessary systems in place to run a practice safely and effectively and provide a good service to clients.

Table 4.8. Question 2. What are the Positive Aspects of the Practice Accreditation Programme? Cont.

Respondent	Response
25	Allows the practitioner to break up the running of the practice into logical sections, for clearer analysis which in turn facilitate correction of deficiencies.
26	It gives lots of information on how to go about implementation of quality control, how to improve on existing practices and/or how to introduce new aspects of quality improvement.
27	Keeps everybody on their toes and forces you to document well.
28	It forces all the practices to maintain a high level of professionalism and treatment or service to the patient.
29	It promotes a higher standard of physiotherapy in private practice. It leads to more uniformity.
30	It creates checks and balances, so the practitioner can appreciate the importance of issues eg. Good record keeping, good equipment maintenance, and keeping document files.
31	Dit sal 'n hoe standaard van praktyk en praktyk bestuur bevorder. Dit leer 'n mens selfondersoek (It will promote an high standard of practice and practice management. It teaches one self assessment).
32	Improved standards and forces us to do what we know we should do.
33	One can advertise yourself as accredited. Thus doctors and the public will know you work according to certain rules and quality. Hopefully will put an end to physio's just working for money and not quality of treatment.
34	Maintenance of good standards and uniformity in a practice.
35	Standards uniformity.
36	Attention to detail. It will quickly pull up practices that have become shipshod.
37	It gets everybody to make sure that they are giving quality care for each and every patient.
38	The high standard of practice management.
39	Long overdue practical practice management system.

The overwhelming consensus on the positive aspects of the programme was that the programme will improve standards, practice management and utilise quality improvement exercises. The conclusion to be drawn from these responses is that the respondents identified the lack and the importance of structured guidelines in physiotherapy practice. All four aspects of the central theoretical assumption i.e. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice are supported.

Table 4.9. Question 3. What are the Negative Aspects of the Practice Accreditation Programme?

Respondent	Response
1	Sommige dinge is nie sinvol en belangrik nie en word oorbeklemtoon (Some things are not meaningful, nor important and are overemphasised).
2	Baie harde werk aanvanklik (A lot of hard work initially).
3	Financial implications, eg. Performance testing and servicing of equipment. Time consuming re: writing of the procedure manual.
4	None that I can see.
5	? Vooroordele teenoor sekere fisioterapeute deur die ondersoeker (Prejudice of assessors against certain physiotherapists).
6	None
7	None, except perhaps the low profile/priority it enjoys amongst private practitioners.
8	Physio's working in hospitals – they see 16-20 patients and document in hospital file. Now they must also document in practice patient file as well – time consuming.
9	Neem baie tyd op (very time consuming).
10	Not attainable by all, and may be perceived to be elitist. Expensive to run, especially at first.
11	None.
12	None.
13	It requires a lot of time and financial resources which may not be available and this could reduce the number of applicants.
14	Time constraints.
15	Time consuming.
16	Physio lack of knowledge to why it is done.
17	Found it difficult to get all the paperwork sorted out!
18	None.
19	Geen (None).
20	Many forms to be completed.
21	Time consuming. Stress!!!
22	Time consuming in the beginning.
23	Time!
24	None.
25	None.
26	A lot of hard work and time are necessary for implementation and continued monitoring. Neither of the above presently is rewarded by increase in income.
27	Can't think of any.
28	Time consuming.
29	None.
30	It's time consuming.
31	Takes up time to prepare for accreditation and money.
32	Dis 'n tydsame en omslagtige proses. Dit sal aanvanklik baie van jou tyd opneem (It is a prolonged and tedious process. It will initially be very time consuming).
33	Keeping the standard up. Takes a long time and a lot of effort to be accredited.
34	I think there are quite a few things that are unnecessary eg. a mission statement. It takes time & effort to compile and are they worth much?
35	Too costly and excessive administration.
36	Increased time spent.
37	It could be considered to be out of reach/inappropriate to certain geographical areas.
38	None.
39	Time to uphold the standard of practice – when time is of essence the first thing to slip is not necessary the quality of treatment, but the admin around the treatment.

Twelve respondents could not identify any negative aspects of the accreditation programme. Half the respondents cited time as the main

negative factor. Other negative factors were identified as financial constraints, lack of knowledge and increased administration. The negative factors reported support the assumption of remediation of continuous changes in private practice in the central theoretical assumption.

Table 4.10. Question 4. Do You Think Accreditation is Appropriate in the Current Managed Health Care Environment?

Respondent	Response
1	Ja, verbeter die standaard van die praktyk en die diens (Yes, it improves the standard of the practice and the service).
2	Yes, it sets a standard.
3	Yes, ethical and clinical norms tend to be neglected, especially in home practices.
4	Very much so. If we don't start to define whom we are as well as how and what we do, then somebody else is going to do it for us. And it will not be in the best interest to lose that control. Our monetary worth follows on directly from those definitions.
5	Yes!!
6	Yes, finances are becoming more tight and health care funders want value for their money.
7	Absolutely, standards need to be maintained and very often improved.
8	Yes.
9	Beslis (Absolutely).
10	Absolutely. Accredited practices are bound to be better organised and managed ones, they will be able to cope with the complexity of managed care requirements.
11	Yes.
12	Yes.
13	No, because of financial constraints.
14	Beslis. Dit sal die standaard en "image" van fisioterapie verbeter (Absolutely. It will improver the standard and image of physiotherapy).
15	Yes.
16	Yes.
17	Definitely.
18	Yes.
19	Very.
20	Yes, because you always need systems in place.
21	Yes, but it should be acknowledged by others in the health care field.
22	Yes.
23	Yes.
24	Yes, seeing that when taking an oath when graduating, we promise to give the best treatment possible to our patients. That can only be achieved by regularly seeing your standards are up to date. Especially in a constantly growing and changing environment concerning technology and research.
25	Definitely.
26	In terms of business to business negotiations both parties must have a clear picture of the products under discussion. Accreditation ensures a better definite and continued quality control.
27	Absolutely! In times where rationalisation is often aiming at greater productivity which does not necessarily imply greater quality for the consumer, I feel that accreditation cum quality improvement will benefit: a) our client/patient; b) our client/funder; & c) the referring doctors.
28	Yes.
29	Definitely.
30	Yes.
31	Absolutely. I think that MHC will only use accredited practices.
32	Ja, veral omdat ons nog self die standaarde daar kan stel (Yes, especially because we can still set the standards ourselves).

Table 4.10. Question 4. Do You Think Accreditation is Appropriate in the Current Managed Health Care Environment? Cont.

Respondent	Response
33	Very! We have to wake up and be prepared.
34	Yes, there are one-man practices in our area that are not on standard at all. Everything gets evaluated these days in the health system – so also physiotherapy services.
35	Most likely.
36	Probably.
37	Certainly.
38	Yes.
39	Yes, I think so.

Only one respondent identified the accreditation programme as inappropriate in the current managed health care environment due to financial constraints. One responded summarised the perceived importance of the accreditation programme in the managed health care environment as: "In times where rationalisation is often aiming at greater productivity which does not necessarily imply greater quality for the consumer, I feel that accreditation *cum* quality improvement will benefit: a) our client/patient; b) our client/funder; & c) the referring doctors. All four aspects of the central theoretical assumption ie. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice are supported".

Table 4.11. Question 5. Define Accreditation in Your Own Words.

Respondent	Response
1	Opgradering van dienste om sodoende die beste moontlike standard te handhaaf (Upgrading of services to maintain the highest possible standards).
2	No response.
3	The professional evaluation of clinical, ethical standards and practices.
4	Being able to stand up and say that you have been tested and proven to conduct your practice in a professional and ethical way. To have systems in place that on an ongoing basis improve the way you do things for the benefit of our clients. Being answerable for your actions to your colleagues and clients.
5	'N waarborg aan pasiente / gemeenskap dat 'n sekere minimum standaard te wagte kan wees van enige ge-akkrediteerde praktyk (A guarantee to patients/the community of a certain minimum standard in accredited private practices).
6	Accreditation is professional management, standards and implementation of these and will serve as a continuing reference for standards.
7	Accreditation is a programme/process by which we constantly monitor our own practices and continually strive to improve our service to the public on all fronts.
8	To maintain certain standards.
9	Om 'n sekere basiese standaard daar te stel sodat pasiente, dokters en fisio's kan weet die praktyk handhaaf dit (Setting a certain basic standard for patients, doctors and physiotherapists to know that a practice maintains these).
10	The standard that practices should aspire to, and maintain when achieved.
11	The attainment and ongoing evaluation of standards of excellence in private practice.
12	Setting of good standards which are within the scope and achievable by all physios.
13	To raise the standard and image of physiotherapy which are available to all physiotherapists.
14	Neerlê en voldoen aan 'n hoë standard van fisio dienslewering, QM (The laying down of and compliance to a high standard of physiotherapy service delivery, Quality Management).
15	It is a set of high standards that a practice must strive to reach.
16	Providing a standard so that the profession and patient can benefit the most from the implementation.
17	Maintaining standards within the profession by monitoring constantly – to ensure excellent care.
18	To comply to universal standards set.
19	Upgrading the standard and efficiency of my practice to aim for a more professional service eg in the pursuit of excellence.
20	Improving the standards of the practice so that your practice has the "stamp of approval".
21	Setting certain standards. Assessing if those standards have been met. Giving the practice credit for maintaining those standards.
22	A standard which is set and by which you have to apply.
23	Setting of a standard of patient care and running of a practice and then maintaining and improving of standards.
24	Evaluation a practice to see if it maintains the standards set out by the SASP and PhysioFocus.
25	An audit/review of systems and protocols which should be in place.
26	A voluntary system of adherence to a set of minimum standards and a commitment to maintaining and improving these standards, in the long term.
27	Quality improvement for: a) patients – optimal care in every aspect of treatment; b) funders – improved recording and data collection may lead to less over-servicing and hence cost cutting.
28	No response.
29	Set of standards of high quality a practice must measure up to.
30	Defining and improving the standards of physiotherapy.
31	It is the defining of standards to which practices in SA should aspire.
32	Die verhoging in standaard om die praktyk en funksionering meer effektief te laat verloop (The increase in standards to make the practice and functioning of the practice more efficient).
33	A high standard on all aspects of physio private practice.
34	Evaluation of the efficiency, quality of service and management.
35	Recognition of acceptable standards of practice.
36	Defining the attributes of a practice.
37	The attainment and maintenance of predefined standards.
38	To make sure that you stay on top all the time in all aspects of the field of physiotherapy.

Table 4.11. Question 5. Define Accreditation in Your Own Words. Cont.

Respondent	Response
39	Setting standards for effective and qualitative practice management to support effective and qualitative patient treatment.

Two respondents did not respond to this question. The remaining respondents identified the main aspect of accreditation as the implementation and maintaining of standards of physiotherapy practice. Again the responses support all four aspects of the central theoretical assumption ie. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice.

Table 4.12. Question 6. Did you Find the Workbook Helpful in Your Preparation?

Respondent	Response
1	Ja, baie (Yes, a lot).
2	Yes, lots.
3	Yes
4	Yes.
5	Yes.
6	Sometimes, more examples to get ideas of what is expected, would be useful.
7	Yes. Initially we need to work from examples and alter them to suit the specific needs for your practice.
8	Very.
9	Ja (Yes).
10	Yes.
11	Yes.
12	Yes, many would find it just too much to cope with and give up, in spite of good intentions.
13	It is good, but daunting in a small practice.
14	Ek sou andersins nie geweet het waar om te begin nie (I would otherwise not have known where to start).
15	Yes.
16	Yes.
17	Yes.
18	Yes.
19	Very, but more so now as I apply it to all new implementation.
20	Yes.
21	Yes.
22	Yes.
23	Yes.
24	Yes.
25	Yes.
26	Yes, it is logically set out and easy to follow.

Table 4.12. Question 6. Did you Find the Workbook Helpful in Your Preparation? Cont.

Respondent	Response
27	Yes, It is a time consuming, but ultimately easier way to prepare for accreditation.
28	Yes.
29	Yes.
30	Yes.
31	Yes.
32	Beslis (Definitely).
33	Yes.
34	Yes, without it you are lost.
35	Yes.
36	Yes, interesting and informative.
37	Yes.
38	Yes.
39	Yes.

Only one respondent stated that the workbook should have contained more practical examples, but was otherwise useful. The rest of the respondents regarded the workbook as helpful and necessary in the preparation for the accreditation process. The inclusion of a learning programme pre- and post accreditation was supported in these responses.

Table 4.13. Question 7. Is Specific Training Necessary for the Use of this Manual? If Yes, 7.1 Who Should do the Training? 7.2 How Long Should the Training be?

Respondent	Response	Response to 7.1.	Response to 7.2.
1	Nee (No)		
2	Yes	Accreditation committee	?
3	Yes	PhysioFocus	No response
4	Yes	Accreditation Committee	10-16 hours
5	Yes	Surveyors	15-16 hours
6	Yes	Surveyors	1-2 days
7	Yes	Experienced/retired physios	Weekend course
8	Yes	Accreditation committee	5 days
9	Yes	Accreditation committee	Weekend initially and then follow-up after 2 months.
10	Yes	Accreditation committee	Weekend course
11	No		
12	Yes	Accreditation committee	Weekend course
13	Yes	Accreditation committee	Weekend course
14	Yes	Accreditation committee / surveyors	Weekend course
15	No		
16	No	A help-line should be available	
17	Yes	Accreditation committee	Weekend course
18	Yes	Accreditation Committee	1-2 days
19	No	May be a help-line?	

Table 4.13. Question 7. Is Specific Training Necessary for the Use of this Manual? If Yes, 7.1 Who Should do the Training? 7.2 How Long Should the Training be? Cont.

Respondent	Response	Response to 7.1.	Response to 7.2.
20	No		
21	Yes	Accreditation committee	2 days
22	No		
23	Yes	Accreditation committee	Weekend course
24	No	The workbook shows you how	
25	Yes	Accreditation committee	?
26	No		
27	Yes	Accreditation committee	Weekend course
28	No		
29	Yes	Surveyors	1-2 days
30	Yes	Accreditation committee / surveyors	As long as it necessary
31	No	The workbook is self explanatory	
32	Yes	Surveyors	Weekend course
33	Yes	Accreditation committee	Weekend course
34	No	There must be a help-line	
35	No	Phone in facility	
36	No	Help-line	
37	Yes	Surveyors	1-2 days
38	No	Perhaps a help-line?	
39	Yes	Accreditation committee	Weekend course

More than half of the respondents identified the need for specific training regarding the use of the practice accreditation manual. The suggestion was that the training should be offered by the accreditation committee and / or the accreditation surveyors. The length of training suggested varied from 10 hours to five days, with most respondents suggesting a weekend course. A further six respondents suggested the services of a telephonic help line. The responses to this question supports training as contained in the central theoretical assumption.

Table 4.14. Question 8.1. Was Someone Available to Answer Your Queries About the Implementation of the Accreditation Programme? 8.2. If so, Who was Available?

Respondent	Response to 8.1.	Response to 8.2.
1	Nee, nooit (no, never)	Very negative point
2	No response	
3	Yes	Winifred Bowman
4	Yes	Winifred Bowman
5	Yes	Too far away
6	Yes	Accreditation committee
7	Yes	Winifred Bowman
8	Yes	Winifred Bowman
9	Yes	Winifred Bowman
10	Yes	Winifred Bowman
11	No	
12	Yes	Accreditation committee
13	Yes	Winifred Bowman
14	Yes	Accreditation committee
15	No	We did not need anyone
16	Yes	Winifred Bowman
17	No	Did not need
18	Yes	Winifred Bowman
19	Yes	Accreditation committee
20	Yes	Accreditation committee
21	No response	
22	Yes	Winifred Bowman
23	Yes	Accreditation committee
24	Yes	Practice manager
25	Yes	Winifred Bowman
26	Yes	Winifred Bowman
27	Yes	Accreditation committee
28	Yes	Accreditation committee
29	Yes	Practice manager
30	Yes	Winifred Bowman
31	No response	
32	Yes	Accreditation committee
33	Yes	Winifred Bowman
34	No	Not needed to
35	No	No need
36	Yes	Winifred Bowman
37	Yes	Winifred Bowman
38	No	Work book sufficient
39	Yes	Winifred Bowman

Only two respondents experienced problems in contacting someone regarding assistance with the implementation of the accreditation programme, despite the widely published contact details. A further five respondents did not need any assistance. In this question the assumption of training is supported.

Table 4.15. Question 9. What is the Value of Accreditation in Your Practice?

Respondent	Response
1	Opgradering van dienste om sodoende die beste moontlike standaard te handhaaf (Upgrading of services to maintain the highest possible standards).
2	Daar is geskrewe reels, voorskrifte ens. vir die bestuur van die praktyk. Opvolgwerk is baie maklik. Gee prestige aan die praktyk (There are written rules, prescriptions etc for the management of the practice. Follow-up work is very easy. It gives the practice prestige).
3	Upgraded safety measures, CPR course completed. Clinical record systems and statistic system upgraded.
4	Puts common sense and good practice down on paper – and makes it measurable. Measurement motivates and so an exciting vicious circle begins.
5	Meer ge-organiseer en beter bestuur (More organised and better management).
6	Improved practice management and patient care. Good PR tool. Improve private practice standing with health funders because of better stats and outcomes available.
7	Tremendous. Allowed me to develop goals and objectives for the practice.
8	Documentation is much better.
9	Het beslis standaarde van pasient data opgebring (Has definitely improved standards of patient data).
10	It has improved my practice enormously, completely changed my record keeping, which would now clear close scrutiny.
11	It ensures that accepted standards and practices are adhered to and this is a positive aspect for patients and doctors.
12	Better management.
13	Better record keeping and admin.
14	Instel van goeie administrasie stelsel. QM beplanning (Implementation of a good administration system. Quality management planning).
15	It places your practice above other practices.
16	I really strive to deliver the best service possible to my patients – it also helped to structure everything in my practice.
17	It will improve my record keeping ++ ! It will ensure my machines all work.
18	Management and organisation skills have improved. Performance will improve. Better record keeping.
19	Record keeping has improved, also the standard of management and admin.
20	We are providing an improved standard of practice.
21	We can see where our shortcomings are and adjust accordingly.
22	It puts us in the unique position of complying to a norm – a great marketing tool.
23	Gets staff and myself doing things as they should and improving all the time.
24	It keeps us to standard giving the best possible treatment and services.
25	Keep necessary systems in place. Keep staff on their toes and therefore enables practice to provide a good service to clients. Good service leads to growth in practice.
26	It has forced you to upgrade almost all systems from cleaning to record keeping.
27	The streamlining of existing practices and routines. It also provides an accurate perception of own as well as staff's strengths and weaknesses.
28	Puts us one step above other practices and patients receive better quality treatment.
29	For me to think about general safety again, everyday.
30	Improving and maintaining of standards.
31	Improved admin.
32	Much better practice management – I wish I knew this before!
33	Improved standard. Up to expected standard. I am very proud.
34	No response.
35	Not viable in part-time practice.
36	Improved practice management (should be taught at university).
37	It advertises that my practice is of a high standard in all fields.
38	My whole attitude changed from "just doing" to "thinking about what I am doing and why".
39	To ensure effective running of the practice and to inform patients and doctors that quality management is available in this practice.

Only one respondent did not respond to this question and one respondent did not find the process viable in a part time practice. The overwhelming majority of respondents identified improved standards, improved practice management, improved service delivery, improved safety and quality improvement activities as the value added to their private practices. All four aspects of the central theoretical assumption ie. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice are supported.

Table 4.16. Question 10. Will You Recommend the Practice Accreditation Programme to Your Colleagues? Please Motivate Your Answer.

Respondent	Response
1	Ja, opgradering van dienste om sodoende die beste moontlike standard te handhaaf (Yes, upgrading of services, so as to maintain the highest possible standards).
2	Ja, daar is geskrewe reels, voorskrifte ens. vir die bestuur van die praktyk. Opvolgwerk is baie maklik. Gee prestige aan die praktyk (Yes, there are written rules, prescriptions etc for the management of the practice. Follow-up work is very easy. It gives the practice prestige). Same response as to question 9.
3	Yes, due to so many other professions encroaching on our profession eg. pain clinics (APS), chiropractors, biokinetisists, practice accreditation will improve the image of our profession.
4	Yes, the more of us prepared to stand up and prove our worth in the market place, the more chance we have of survival – professionally and financially through the tough times of managed health care that lies ahead of us.
5	Yes, dit sal 'n meer effektiewe fisioterapie diens tot gevolg hê (Yes, it will result in a much more efficient physiotherapy service).
6	Yes, in the long run the running of a practice will be much easier and improve practice management generally. It is a great PR tool.
7	Yes, the more practices become accredited, the more our patients and profession wll benefit. Improves general standard of private practice in SA.
8	Yes.
9	Yes, it will improve the physiotherapy service uniformly.
10	Yes, in order to force practices to write up and formalise systems that may already be in action in their practices.
11	Yes, I feel it promotes professionalism.
12	Yes, provided training is given.
13	Yes, it will make us more professional and efficient.
14	Ja, maak jou bewus van baie dinge wat nie 100% gedoen word nie, veral admin. Skep die geleentheid vir navorsing dmv statistieke (Yes, makes you aware of many things that are not performed 100%, especially administration. It creates the opportunity for research by means of statistics).
15	Yes, it motivates you to achieve higher standards.
16	Yes, I hope that future medical aids will force practices to be accredited before they do business. I think professionalism will benefit from it as most physio's just "get" from the profession and never "give".
17	Yes, I think they will see the value once they understand the concept. We owe it to the patients to give excellent care.
18	Yes.

Table 4.16. Question 10. Will You Recommend the Practice Accreditation Programme to Your Colleagues? Please Motivate Your Answer. Cont.

Respondent	Response
19	Yes. It is actually things we know we should be doing and it will be satisfying and rewarding to do it.
20	Yes, it's a good process to put your practice through to evaluate and improve your standards.
21	Yes, so that they can also be up to standard.
22	Yes, eventually everybody will have to comply – patients require a standard that would benefit them.
23	Yes, I think wherever possible all practices should be accredited to improve management of physio generally.
24	Yes, it sees that you keep giving service expected, evaluate your service as physiotherapist, otherwise you could stagnate and not progress with the growing competitive environment.
25	Yes, physiotherapy practices pop up everywhere like mushrooms. We need to upgrade the standard of physiotherapy in SA and keep it up. We also need proof to doctors that we provide a good service for the future of the profession.
26	Yes, in managerial terms, it allows one to more clearly define the system in running professional practice and to take remedial steps where quality is blow par.
27	Yes! The profession as a whole will benefit from a tighter implementation of quality treatment and subsequently gain better status in the eyes of all who are dealing with us: referrals, funders and above all, patients/clients.
28	Yes. Helps to keep the standard at the practice high.
29	Yes, it enables you to re-evaluate your practice continually and promotes higher standards.
30	Yes. Firstly it is a marketing tool which MHC will acknowledge as a standard whereby practices are measured. Secondly, it helps the practitioner to think about issues re the running of the practice eg. safety, infection control, professionalism etc.
31	Ja, dit stel 'n hoër standaard van funksionering daar. Alles funksioneer effektiewer sonder enige area/aspek wat aan twyfel oorgelaat word (Yes, it sets a higher standard of functioning. Everything functions better without any area/aspect left in doubt).
32	Yes, yes! We should all be up to the prescribed expected standard.
33	Yes.
34	Yes, with reservations, as implementation in a part time practice is very difficult.
35	Yes.
36	Yes, see previous answers.
37	Yes, it opens up your way of thinking. I think we all tend to be narrow-minded in our way of thinking and this programme forces you to start thinking laterally.
38	Yes, I wish every practice in the country would be accredited.
39	Yes, it would be very good for our professional image.

All the respondents have indicated that they would recommend the implementation of the practice accreditation programme. Reasons cited include maintenance of practice standards, practice prestige, improving the image of the profession, benefits to patients and the profession through better service delivery, improved practice management, staff motivation, improved lateral thinking skills and improved public relations. Once again all four aspects of the central theoretical assumption ie. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice are supported.

Table 4.17. Question 11. What Suggestions do You Have for Future Upgrading of the Practice Accreditation Programme?

Respondent	Response
1	Geen op die oomblik (None at the moment).
2	No response.
3	Will be able to comment at a later stage.
4	Encourage research, publishing of articles in medical journals, giving talks to other professions etc. as part of the mandatory annual accomplishments along with CPR and other courses.
5	?Kan "fisioterapeut akkreditasie" aan "praktyk akkreditasie" gekoppel word (Can physiotherapist accreditation be linked to practice accreditation)?
6	More practical examples, especially for record keeping, staff management, general management.
7	Integrate the programme into the training of undergraduates.
8	No response.
9	Not yet.
10	I feel that a pre-survey run-through will be valuable, as in most cases, the practices in the first stage of implementation of the programme were significantly improved between the first and second surveys.
11	No response.
12	None.
13	None.
14	Practice principles should be trained in practice management.
15	None.
16	More practical ideas, especially on management, record keeping and quality improvement.
17	Keep it up to date with world trends.
18	No response.
19	More training undergraduate and post graduate.
20	None.
21	None.
22	Reduce paperwork.
23	None at the moment.
24	No response.
25	Not sure.
26	Later, better system of clinical data collection and analysis so that standards of treatment on an outcome-based system will also form part of being an accredited practice.
27	National and international trends should be monitored and implemented.
28	No.
29	More training!
30	No response.
31	More training please, especially management and quality improvement.
32	Please, training in the Northern Province.
33	Less paperwork.
34	None.
35	None.
36	Not yet!!!
37	More training, also help with job descriptions and management.
38	No response.
39	More training on management on undergraduate level.

Many respondents felt that they are not yet in a position to give suggestions for future updates of the programme. Suggestions included management training (especially record keeping, job descriptions, staff

management and quality improvement training) at undergraduate and post graduate level. Other suggestions included the implementation of a data collection and analysis system for clinical outcomes of patient care, clinical skills accreditation and the monitoring of national and international trends in quality improvement. All four aspects of the central theoretical assumption ie. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice are supported.

Table 4.18. Any Other Comments

Respondent	Response
1	Dit het 'n lang tyd geneem om the implementeer (It took a long time to implement).
2	None.
3	None at this stage.
4	Accreditation marketing needs to go wider than just our profession. Let the other allied professions and the man in the street know they are in good hands.
5	Goeie werk van die akkreditasie kommittee om alles van die grond af te kry (Good work by the accreditation committee to get everything off the ground).
6	Keep up the good work! Well done on the work done this far. We appreciate it.
7	Actively promote process to others in our profession.
8	None.
9	No response.
10	It is important to maintain these standards. Regular self-assessment questionnaires should be completed to ensure maintained standards.
11	No response.
12	No response.
13	Training is a must!
14	Baie dankie vir al julle harde werk (Thank you for all your hard work)!
15	None.
16	Thanks for all your hard work in implementing this. Good luck!!
17	None.
18	No response.
19	No response.
20	How can we thank you guys for all the work you put in – all the work that only you know how much. Thank you!
21	No response.
22	None.
23	Great manual. Thanx!
24	No response.
25	No.
26	None.
27	Thanks to Winifred and her committee for the vast amount of hard work and persistence that has brought accreditation this far.
28	There could be an inherent danger of practices preparing for accreditation by implementing rules on documentation and other admin functions and in doing so, lose track of the first requirement of quality treatment ie. rendering superior physiotherapy.
29	None.
30	No response.
31	No response.

Table 4.18. Any Other Comments. Cont.

Respondent	Response
32	No response.
33	You have done an excellent difficult job. Only you know how hard it has been. We can only say: thank you.
34	None at the moment.
35	No response.
36	No, not at the moment.
37	No response.
38	No response.
39	Very good work – thank you!

Most of the respondents made no further comments on the accreditation programme. Many of the respondents were appreciative of the work done on the practice accreditation programme. Other comments included more training, promotion of the accreditation programme to the rest of the physiotherapy profession, as well as the regular completion of a self-assessment questionnaire on implemented accreditation activities. All four aspects of the central theoretical assumption ie. quality physiotherapy practice; professional and personal development; monitoring of the progress of the pre- and post accreditation process; and monitoring and remediation of continuous changes in private physiotherapy practice are supported.

4.4.2.5. The Researcher's Evaluation of the Implementation of the Learning Programme of the PhysioFocus Practice Accreditation Programme

The PhysioFocus practice accreditation programme addresses the needs of the physiotherapy profession, the public (patients) and funders to provide quality care and quality practice management. The PhysioFocus practice accreditation programme also enables physiotherapists in private practice to re-evaluate their practices continually and gain recognition for the clinical and administrative organisation in their practices. In the opinion of the researcher, the programme is very necessary as a starting point for structured quality improvement activities in physiotherapy private practice in South Africa. It is by no means a complete solution, but has made physiotherapy practitioners aware of the minimum standards of private practice. It was clear from the initial stages of implementation of the programme that many physiotherapists in private practice

are very concerned about the maintenance of standards of physiotherapy (or slipping of standards), standard of practice management, the image of the physiotherapy profession, as well as quality improvement issues in private practice in South Africa. The general concern about standards of practice is that there is much variation amongst practices, with no uniform, accepted minimum standard in place. This leads to great variation in the quality of service delivery, impacting negatively on the professional image of physiotherapy. The standards contained in the PhysioFocus practice accreditation programme should address this to a large extent and make physiotherapists conscious of the expected minimum standard of practice. The implementation of these standards should lead to improved and more uniform quality service delivery to the benefit of the profession, public and funders.

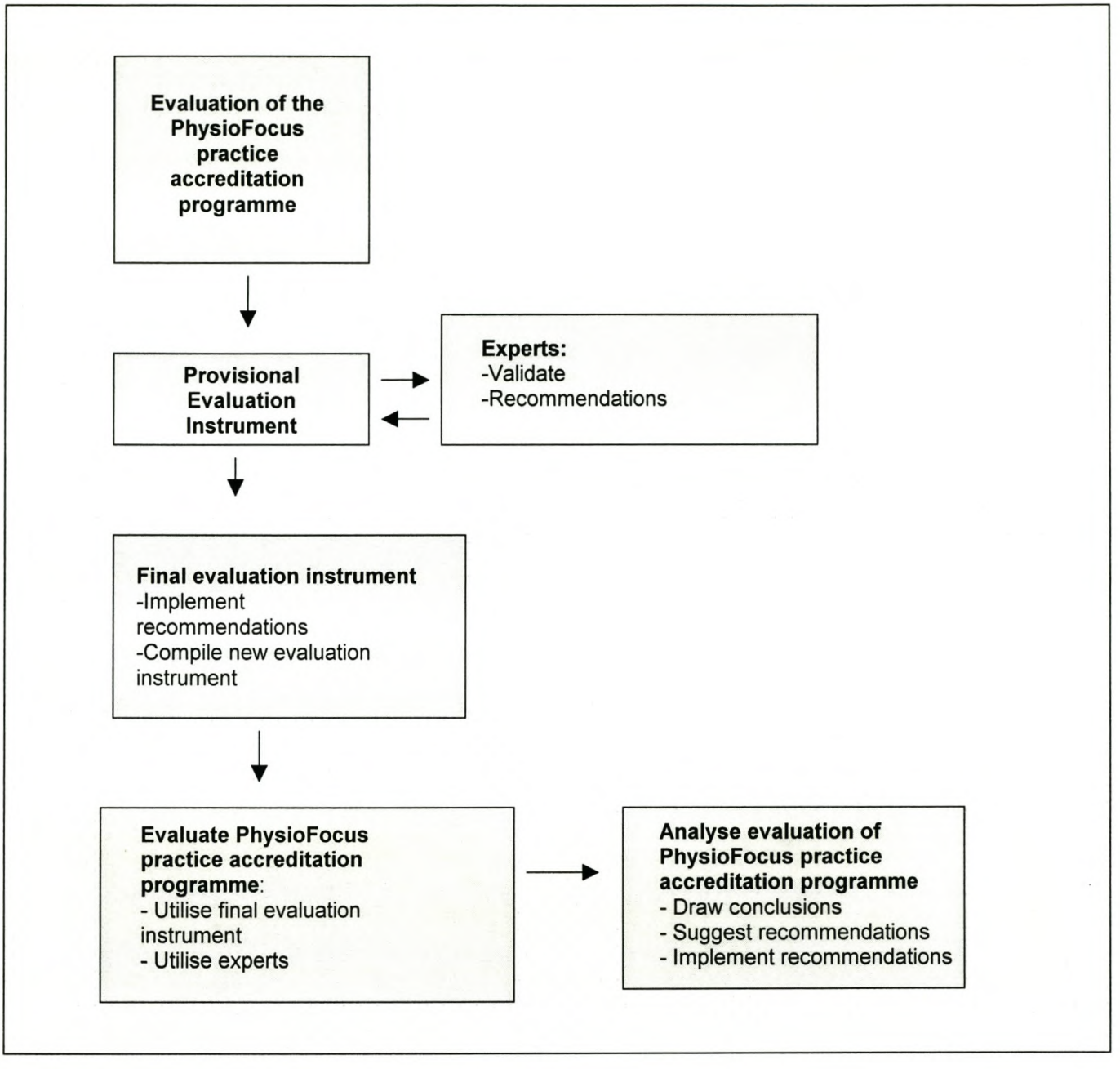
A lack of knowledge of practice management is also a great concern. More and more physiotherapists in South Africa find employment in private practice due to the lack of employment in the state owned health institutions. Many physiotherapists therefore embark on setting up their own practices in the private sector without sufficient knowledge or skills in practice management. Some practice management issues are contained in the PhysioFocus practice accreditation programme to allow private physiotherapy practitioners to gain more knowledge and skills in practice management, but it is by no means sufficient nor is it complete.

4.4.3. Evaluation of the PhysioFocus Practice Accreditation Programme

The evaluation of the PhysioFocus practice accreditation programme was performed according to the final evaluation instrument (see Appendix two). The provisional evaluation instrument was developed according to Mason's steps in standard formulation (see Table 2.20.), the identified empirical indicators, based on the ALM and the researcher's experience. The provisional evaluation instrument was then validated by identified experts. The selection criteria for the experts included health care experts in quality improvement activities, physiotherapy training and physiotherapy practice accreditation. This evaluation was conducted according to the group criteria set out by Lynn

(1986:383), namely by using a minimum of three experts and a maximum of ten. A total of five experts were chosen (see final evaluation tool in Appendix two). The provisional evaluation instrument was distributed to the respondents by means of facsimile or e-mail. The responses were collected after two weeks. The responses were analysed and the recommendations implemented in a final evaluation instrument for the evaluation of an accreditation programme for private physiotherapy practice in South Africa. See Figure 4.2. for the process of the evaluation of an accreditation programme for private physiotherapy practice in South Africa.

Figure 4.2. Process for the evaluation of the accreditation programme



4.4.3.1. Structure of the Provisional Evaluation Instrument

The provisional evaluation instrument consisted of:

- a cover page;
- instructions on how to use the evaluation instrument;
- the identity and qualifications of the evaluator;
- general summary;
- commendations; and
- comments (see Appendix one for the provisional evaluation instrument).

Aspects of evaluation in the provisional evaluation instrument included the following:

- fundamentals of professional physiotherapy practice in South Africa;
- legislative framework;
- outcomes-based education;
- quality improvement and accreditation; and
- a scale of compliance, partial compliance or absence.

4.4.3.2. Recommendations for the Final Evaluation Instrument for the PhysioFocus Practice Accreditation Programme for Private Physiotherapy Practice in South Africa

Recommendations made by the experts are described according to the responses from the different respondents. These responses are recorded verbatim.

Respondent One:

- The language should be simplified and made more user-friendly. The simpler the language the better the compliance.
- The main headings should be numbered.
- The main headings should be described better and highlighted.
- In number one, change "Boundaries of exclusiveness are found in evidence of" into simpler language. For example: What criteria set physio's apart from the rest of the population?

- In number one, change "evidence of standards from the professional Board of physiotherapy" to "evidence of the existence of standards of practice from the Professional Board of physiotherapy".
- In number one, change "evidence of disciplinary steps to be taken" to "evidence of disciplinary structure".
- In number one, reword "evidence of a trust relationship".
- In number three, change "design down process" to "implementation of management decisions to the lower level".

Respondent Two:

- Include a fourth component to the scale and change to a score system, exceed compliance (3), compliance (2), partial compliance (1) or absent (0). The final score should be presented as a percentage score.
- Include more verbs to describe concepts.
- Include criteria of PhysioFocus practice accreditation programme.
- Tighten up concepts to prevent repetition.
- Cut "General Summary" and "Commendations" and only use "Comments" and "Recommendations".
- Change instrument headings to those of the standards in the PhysioFocus practice accreditation programme.

Respondent Three:

- Change "Evidence of transformation according to the health policy" to "Evidence of equal and equitable transformation to the health policy" in number one.
- In one, change "Evidence of sustained excellence through standards" to " Evidence of sustained clinical excellence through standards".
- In three, "Demonstration of outcomes" is vague and unclear. Describe this better.
- Number four: "Quality Improvement and Accreditation" should be divided into two sections, namely, clinical and managerial activities. The activities of QI and accreditation should be evaluated for both activities.

Respondent Four:

- Use the same typing font in all the components of the instrument.
- Editing of the final instrument is essential.
- The content of the instrument is relevant, but needs some reformulation.
- In one: "Evidence of registration with HPCSA". What are their minimum update requirements?
- In one: "Evidence of standards from the Professional Board of Physiotherapy". What type of standards i.e. standards of practice – be specific.
- In one: "Evidence of up to date knowledge". What is your judgement for that – be more specific.
- In four: change "Basic components include" to "Basic components of quality improvement and accreditation are:".
- In four: change "Philosophy" to "A philosophy that reflects the value framework of the service".
- In four: "Value framework". What about the value framework?
- In four: "Mission". Change to " the mission of the practice where the service is rendered".
- In four: "Critical factors". Of what?
- In four: "Documentation". Of what?

Respondent Five:

- Define quality improvement in terms of outcomes-based clinical treatment.
- Avoid repetitions.
- In four: "Principles to be implemented are:" change to "Principles to be implemented during training are:".
- In four: "Standards formulated according to:" Change to "Are the standards written showing:".
- In four: "QI": write in full throughout.
- In four: "QI model utilised". Which model is used?

The suggested recommendations were analysed and implemented in the final evaluation tool according to overall consensus of the experts. See Appendix two

for the final evaluation instrument for the PhysioFocus practice accreditation programme for private physiotherapy practice in South Africa.

4.4.3.3. Process of Implementation of the Evaluation of the PhysioFocus Practice Accreditation Programme

The final evaluation instrument was utilised to evaluate the PhysioFocus practice accreditation programme. The instrument was distributed to the experts for perusal. A meeting was held with the physiotherapy experts two weeks after distribution in July 2001, to evaluate the PhysioFocus practice accreditation programme. The meeting was attended by all five experts and the following input was given collectively by the five experts (see section 4.4.1.3.):

- When the standards are updated, opinions should be gained from a wide variety of practices, both economically and geographically diverse in order to apply a holistic approach.
- The relevant parts of the legislation should be summarised and added to the PhysioFocus practice accreditation programme manual as an appendix.
- In the introduction of the PhysioFocus practice accreditation programme manual, the boundaries of the programme should clearly be stated (which issues it addresses and the issues that are not addressed).
- Copies of all the relevant legislation should be present on the practice premises for application, referral and perusal by staff.
- Clinical standards should be included and should be outcome based.
- Adequate business management knowledge should be a prerequisite for applying for accreditation. This should be part of under- and postgraduate training.
- External education courses must be outcomes-based. The courses should have to be accompanied by a competency certificate and not just an attendance certificate.
- Risk management as part of business management, clinical skills and patient management should be included as an external education course.

- All courses related to the PhysioFocus practice accreditation programme should be in accordance with OBE, the SAQA Act, The Skills Development Act and The Higher Education Act.

Steps four and five of the FOCUS-PDSA model were implemented as part of the results of the evaluation of the PhysioFocus practice accreditation programme. The researcher contacted the PhysioFocus practice accreditation committee to establish a date for the analysis of the report with recommendations of improvement of the PhysioFocus practice accreditation programme. By utilising the final evaluation instrument for the evaluation of the current PhysioFocus practice accreditation programme, a score of 204 out of a possible 330 points (62%) was achieved (the total score refers to the maximum points that can be allocated during an evaluation). The assumption can therefore be made that the current PhysioFocus practice accreditation programme is not entirely compliant to South African physiotherapy practice. The PhysioFocus practice accreditation committee will decide on the structure of the implementation of the recommendations, timeframe for implementation and future actions.

4.5. SUMMARY

Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to the subject matter. This indicates that qualitative researchers study situations or matters in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to these situations or matters. Qualitative researchers deploy a wide range of interconnected methods, hoping to get a better understanding of the subject matter at hand.

The different methods of data collection; the analysis for the evaluation of the PhysioFocus practice accreditation learning programme; and the evaluation of the PhysioFocus practice accreditation programme were described in this chapter. Chapter five consists of the conclusions, limitations, recommendations and the final summary.

Chapter Five

Summary, Conclusions, Limitations and Recommendations

We are what we repeatedly do. Excellence, then, is not an act, but a habit.
ARISTOTLE

5.1. INTRODUCTION

In Chapter one the introduction, overview and the problem statement of the research were described. Chapter two dealt with the literature research which included the foundations for professional physiotherapy, the legislative framework, outcomes-based education and quality improvement and accreditation. In Chapter three the research design, research methodology and the development of an evaluation instrument were described. Chapter four included the data collection, analysis and results. In this Chapter a summary, conclusions, limitations and recommendations are described.

5.2. RATIONALE OF THE RESEARCH

It is not easy to live through a day without hearing, seeing or reading something about quality. The health care industry was late to enter the quality arena (Carey & Lloyd, 2001: 2; Naidoo & McSharry, 1999: 293). Quality assurance has been practised for many years, but it is only recently that quality improvement as defined by the principles of continuous quality improvement has been recognised by the health care industry. Quality assurance focussed on identifying poor service providers, rather than on defective processes. When a quality improvement approach is taken, there are two options for realising improvement, namely, reducing the variability in the process and/or shift the process in the desired direction. The application and acceptance of a quality improvement perspective in the health care industry requires a fundamental shift in the way health professionals view their world, in other words – a paradigm shift (Carey & Lloyd, 2001: 3). In the health care industry it was traditionally the providers of care who defined quality in health care. With the advent of managed health care in the mid 1980's, customers (the health care funders and patients) entered the growing debate about quality and cost of health care. It was therefore essential to address the need for quality improvement processes and activities in private physiotherapy in South Africa.

Every physiotherapy practice is confronted with its inherent problems on a daily basis. It requires a purposeful group effort to manage these problems effectively. Management of these problems can be reactive by means of routine crisis management, or proactive by the implementation of a formalised quality improvement system that will facilitate the delivery of quality physiotherapy service (Muller, 1996b: 72). A world-class physiotherapy practice creates dynamic processes that:

- exceed compliance of customer needs, desires and expectations;
- provides distinctive, value-added service; and
- build requisite clinical and competitive capabilities.

Such a practice will utilise management approaches and strategies to develop superior core competencies and nurture accelerated improvements in human assets, organisation, clinical and management technology, clinical skills and communication (Roth, 1993: 1).

Accreditation in physiotherapy is a new and fundamental concept in health care provision. With the acquisition of the Australian Physiotherapy Association practice accreditation programme, it was never assumed that it would fulfil all the criteria for South African physiotherapy conditions. It was thus essential to research the literature to identify indicators for accreditation according to South African conditions. Accreditation necessitates training. South Africa is currently in the era of outcomes-based education (OBE). It was therefore apt to include criteria for OBE in the literature research.

5.3. GOAL OF THE RESEARCH

The research goal was to evaluate the PhysioFocus practice accreditation programme and to make recommendations on the learning programme for accreditation in private physiotherapy practices.

The objectives of the research were divided into three phases, namely:

- Phase one: to explore the literature on accreditation and quality physiotherapy practice in order to identify empirical indicators for the development of a provisional evaluation instrument for the PhysioFocus practice accreditation programme ;
- Phase two: to identify remedial actions to be implemented in the learning programme for accreditation in private physiotherapy practices. This phase was conducted by means of an open-ended, semi-structured questionnaire (see Appendix three) which was completed by the physiotherapists in the target population. The results were analysed and recommendations made; and
- Phase three: to evaluate the accreditation programme implemented in selected voluntary private physiotherapy practices. A provisional evaluation instrument (see Appendix one) was formulated according to the empirical indicators identified in phase one. The provisional evaluation instrument was sent to the physiotherapy experts for validation. The recommendations from the expert physiotherapists were implemented and a final evaluation instrument (see Appendix two) formulated. The final evaluation instrument was utilised to evaluate the PhysioFocus practice accreditation programme.

The exploratory and descriptive components of the goals were realised in the research.

5.4. RESEARCH DESIGN

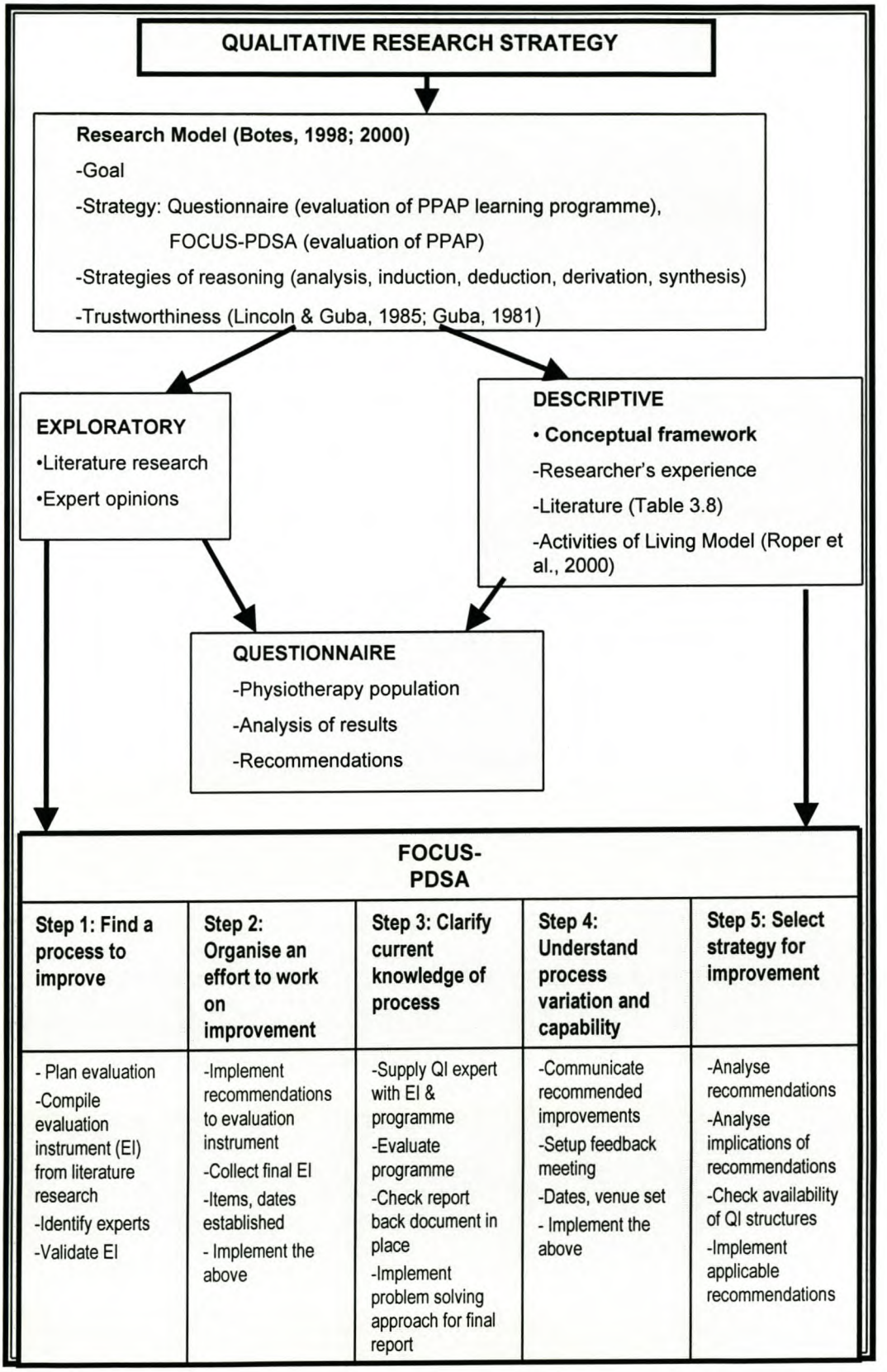
The research design is visually presented in Figure 5.1. The research design included exploratory and descriptive components with a qualitative orientation. Neuman (2000: 21) describes exploratory research as the first stage of a sequence of events in order to know enough to design and execute a second, more systematic and extensive study. Descriptive research presents a picture of the specific details of a situation, social setting or relationship.

Creswell (1998: 15) describes qualitative research as "an inquiry process of understanding based on distinct methodological traditions of enquiry that

explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting". The *how* or *what* questions are examined in order to develop a detailed view of a topic. In designing the research, the researcher works with broad philosophical assumptions; possible frameworks, problems and questions; and data collection through techniques such as interviews, observations, documents, and audiovisual materials (Creswell, 1998: 24).

The FOCUS-PDSA strategy was implemented as the main strategy for evaluation of the PhysioFocus practice accreditation programme (see section 2.4.4.5.i. and Table 3.5.). A partially explanatory strategy by means of a questionnaire was simultaneously implemented to evaluate the learning programme as well as the central theoretical assumption for the PhysioFocus practice accreditation programme (see figure 5.1. for all the steps in the research process). The Botes Research Model (1998; 2000) guided the researcher in the implementation of all the research activities.

Figure 5.1. The qualitative research process



5.4.1. The Evaluation of the Learning Programme of the PhysioFocus Practice Accreditation Programme in Private Physiotherapy Practice in South Africa

A semi-structured, open-ended questionnaire was sent to all physiotherapists in private practice according to the sample selection criteria (see section 1.5.2). The data gathering and data analysis is described in section 4.4.2.3.

Most of the respondents regarded the training as an essential component for practice accreditation, as well as for quality physiotherapy practice. Simultaneously, the central theoretical assumption was realised, namely: The evaluation of the accreditation learning programme for quality improvement in private physiotherapy practice in South Africa should facilitate:

- Quality physiotherapy practice.
- Professional and personal development.
- Monitoring of the progress of the pre- and post accreditation process.
- Monitoring and remediation of continuous changes in private physiotherapy practice.

5.4.2. The Evaluation of the PhysioFocus Practice Accreditation Programme

The evaluation of the PhysioFocus practice accreditation programme was carried out with a valid evaluation instrument. Experts were identified to validate the evaluation instrument. For this purpose a group interview was conducted to evaluate the PhysioFocus practice accreditation programme. Overall consensus was reached on the identification of the areas in the PhysioFocus practice accreditation programme that require remediation. The main areas identified for remediation included the professional-ethical framework, and where business management should be included in the theoretical and practical training of physiotherapists. In the legislative framework, the relevant Acts should be implemented in the physiotherapy practice. Physiotherapists should be familiar

with the relevant aspects of legislation pertaining to the practice of physiotherapy.

5.5. LIMITATIONS

Limitations in the research included:

- Not all the members of the PhysioFocus practice accreditation committee could attend the meeting for the evaluation of the PhysioFocus practice accreditation programme. The committee consists of eight members from all the provinces of PhysioFocus.
- There are no other accreditation programmes available for private physiotherapy practice in South Africa except the PhysioFocus practice accreditation programme. Therefore, there were no other quality improvement / accreditation physiotherapist experts in the private sector, other than the PhysioFocus members that implemented the PhysioFocus practice accreditation programme that could give input. It would have been valuable to obtain additional input from physiotherapist experts that have implemented other physiotherapy accreditation programmes in South Africa.
- Accreditation is not part of physiotherapy in other sectors of employment. It would have been valuable to obtain additional information from the academic and public sectors of physiotherapy practice.
- A pilot study was not performed on the questionnaire to evaluate the PhysioFocus practice accreditation learning programme. The questionnaire was distributed to all physiotherapists in possession of the PhysioFocus practice accreditation learning programme. Only 39 physiotherapists had fully implemented the PhysioFocus practice accreditation programme at the time of the research and therefore only 39 respondents took part in the research. The questionnaire did not reveal any ambiguities, language difficulties or structural inadequacies. The questionnaire can therefore be utilised in its present form in future evaluation of the PhysioFocus practice accreditation learning programme.

5.6. FINAL CONCLUSIONS

The following research questions were posed in Chapter one (see section 1.2.):

- Does the PhysioFocus practice accreditation programme comply with all the requirements in the South African private physiotherapy practice?
- Is the learning programme for accreditation adequate and effective for implementation of the PhysioFocus practice accreditation programme in private physiotherapy practice?

The literature was researched during the period of June 1998 to June 2001. The literature on foundations of professional physiotherapy in South Africa included the training requirements for physiotherapists in order to comply with the compulsory registration with the Health Professions Council of South Africa. The legislative framework researched the Acts applicable to private physiotherapy in South Africa. Twelve Acts were identified and briefly described in Chapter two. Outcomes-based education (OBE) was described according to the types of outcomes, the purpose of OBE and the assessment principles and criteria. Quality improvement as part of the accreditation process included an overview on quality and three quality improvement models, namely the continuous quality improvement model, the WHO model and the Australian Physiotherapy Association model, which formed the basis for the PhysioFocus practice accreditation programme.

The Activities of Living Model (Roper et al., 2000) was selected for a holistic approach to the research and formed part of the conceptual framework. The Activities of Living Model (Roper et al., 2000), the literature research and the researcher's professional experience formed the basis for the compilation of the evaluation instrument for the evaluation of the PhysioFocus practice accreditation programme. The aspects of the Activities of Living Model (Roper et al., 2000) were utilised in the foundations for professional physiotherapy in South Africa and in the legislative framework. The factors that influence the activities of living (biological, psychological, sociocultural, environmental and politicoeconomic) are all incorporated and contained in the foundations for

professional physiotherapy. The activities of living (maintaining a safe environment, communicating, breathing, eating & drinking, eliminating, personal cleansing & dressing, controlling body temperature, mobilising, working & playing, expressing sexuality, sleeping and dying) are all addressed and contained in the legislation pertaining to physiotherapy.

From the research it is deduced that the PhysioFocus practice accreditation programme does not comply with all the requirements in South African private physiotherapy practice. By utilising the final evaluation instrument for the evaluation of the current PhysioFocus practice accreditation programme, a score of 204 out of a possible 330 points (62%) was achieved. The assumption can therefore be made that the current PhysioFocus practice accreditation programme is not entirely compliant to South African physiotherapy practice The omissions were identified and formulated in the recommendations for inclusion in future updates of the PhysioFocus practice accreditation programme. The results have brought about an acute awareness of the lack of standards of practice, outcome standards, uniformity in practice management and the poor professional image of the physiotherapy profession.

It is also clear from the research that the implementation of an accreditation programme is essential. The questionnaire on the learning programme for the PhysioFocus practice accreditation programme supported the central theoretical assumption (see section 5.4.1.) and it therefore supports this statement. The current PhysioFocus practice accreditation programme, however, does not meet all the needs of the private physiotherapy practitioners in South Africa. South Africa is often viewed as a third world country with pockets of first world elements. This current PhysioFocus practice accreditation programme may not be attainable by all physiotherapists in private practice. It is also possible for a private physiotherapy practice to be accredited, but not meet with quality physiotherapy treatment delivery. It is therefore important that all private physiotherapy practitioners have a clear understanding of what is included and excluded in the current PhysioFocus practice accreditation programme. Inherently the programme has problems and should be viewed as a first step of

continuous quality improvement and a total quality management approach in private physiotherapy practice.

5.7. RECOMMENDATIONS

Recommendations forthcoming from this research is described according to the PhysioFocus practice accreditation programme, education and physiotherapy management that will include quality improvement activities.

5.7.1. Current PhysioFocus Practice Accreditation Programme

The development and implementation of the PhysioFocus practice accreditation programme was a first for South Africa and physiotherapists involved in the process should be proud of what they have achieved. In the case of any accreditation / quality improvement programme, the programme should be continuously evaluated and remediated. As this PhysioFocus practice accreditation programme was the basis for a PhD research, it is recommended that the following changes be considered:

5.7.1.1. The inclusion of the relevant legislation in the form of the relevant Acts, as identified in the literature research and the comments of the expert physiotherapists involved in the PhysioFocus practice accreditation programme (see section 5.7.1.2.ii.);
5.7.1.2. Clinical Standards of practice as identified from the results of the questionnaire (see section 5.7.1.2.iii.);
5.7.1.3. The learning programme should reflect the criteria for outcomes-based education (see Appendix two for the final evaluation instrument), as well as the criteria contained in the SAQA Act as identified in the final evaluation instrument (see Appendix two); and
5.7.1.4. Utilise the questionnaire (see Appendix three) on the evaluation of the PhysioFocus practice accreditation learning programme on an ongoing basis for remedial purposes of the programme as remediation is part of the continuous quality improvement process.

5.7.2. Education

Recommendations on education is described according to formal and informal education based on the responses of the questionnaire, the literature research (see Chapter two), the comments of the physiotherapy experts on validating the final evaluation instrument (see Appendix two).

The impact of the research on Higher Education in South Africa revealed that structural changes to the undergraduate learning programme for physiotherapy at tertiary level is imperative. The undergraduate learning programme for physiotherapy should include modules on business management, which includes quality improvement strategies, in depth exposure to the relevant legislation, standards of practice and foundations of professional physiotherapy practice.

5.7.2.1. Formal Education

Formal education includes the following recommendations:

5.7.2.1.i. Business Management

A private physiotherapy practice is run as a business. It is therefore essential that all physiotherapists have training in the basics of business management. In the private physiotherapy practice two levels of management are found, namely, first level management and middle management. At the first level of management, the product physiotherapy is rendered. In middle management the decision making process for the maintenance of the practice is found, i.e. decision making, policy formulation and human resource maintenance/management.

In comparing the management of the private physiotherapy practice with physiotherapy of the public sector, both first and second level management activities are found. However, physiotherapists in advisory capacities in both the private and the public sector, are also found at executive management level.

It is thus recommended that a management process in first level management be implemented as part of the requirements of the basic undergraduate physiotherapy training course. Middle management training courses should be designed and offered at post graduate level (see Tables 4.7 - 4.18).

5.7.2.1.ii. Professional-Ethical-Legal Issues

The functions of the physiotherapist is determined by the Health Professions Council of South Africa. The Medical, Dental and Supplementary Health

Services Act provides the foundation for the profession and is the basis of the ethical and legal issues in physiotherapy practice. For the physiotherapist to function in an ethical-legal environment, she has to adhere to the legal system of South Africa. Physiotherapists do not practice in isolation, they form part of the legal system. It is thus imperative that physiotherapists have sufficient knowledge regarding the relevant legislation pertaining to the practice of physiotherapy.

Therefore it is recommended that the twelve relevant Acts as identified in the final evaluation instrument (see Appendix two) be implemented as part of the training outcomes in the first- and middle management courses.

5.7.2.1.iii. Standards

The development of an internal quality improvement programme is necessary for the successful implementation of any accreditation programme. Standards form an essential part of the quality improvement process. The formulation of standards, management or clinical in orientation, is a structured process and specific training is required in order to formulate valid and reliable standards. It is well known that there are very few health care professionals who are able to formulate standards (Van der Merwe, Kuit, Schmollgruber & Dalgetty, 1995: iv).

It is recommended that the formulation of standards, as well as the formulation of a quality improvement programme be included in the basic physiotherapy

learning programme as outcomes. These should also be included as outcomes in a post basic programme on middle management training (see Tables 4.7 – 4.18).

5.7.2.1.iv. Scientific Methods to Analyse Process Variation and the Development of Improvement Strategies in Quality Improvement

If a practice is truly interested in quality improvement, action must be taken to improve something. Run and control charts provide the basis for taking action and are used to analyse process evaluation (Carey and Lloyd, 2001: 53). A run chart provides a running record of a process over time. Run charts require no

statistical calculations and can be developed easily. They offer a dynamic display of data and can be used in virtually any type of data (i.e. counts of events). Because run charts do not require statistical calculations, they can be understood easily by all members of the quality improvement team. The drawback in using run charts is that they can detect some, but not all special causes of events. The run chart's centre line is the median, which is not sensitive to the absolute value of any single data point (Carey & Lloyd, 2001: 62). Control charts on the other hand, have control limits, which allows one to determine the capability of the process and more accurately, the future behaviour of the process. The control limits provide the basis for determining the capability of the process and for the identification of special causes. The expression "process capability" is used to describe the amount of variation that can be expected around the centre line of a control chart. When using run charts only, one cannot determine the process capability.

Run and control charts do not reveal *how* a process should be improved, nor the reason for a special cause for a problem. The information gathered from constructing the run and control charts (the source and type of variation) provides the basis for the development of an improvement strategy. For example, when a special cause is observed, the origin of the cause should be investigated. If this cause is a negative or undesirable factor, the factors that produce the deviation in the practice process should be eliminated (Carey &

Lloyd, 2001: 151). In the case of a positive event, the cause should also be investigated. If this event can be emulated, it should be implemented as a standard part of the quality improvement process.

It is recommended that a statistical method be used in combination with the quality improvement process in order to analyse the results scientifically on a quantitative basis. This can be done visually by means of diagrams, charts and graphs to present the results of surveys, as well as the recommendations (see section 2.4.3 as well as comments made by physiotherapy experts [section 4.4.1.5.]).

5.7.2.2. Informal Education

Remediation required in the PhysioFocus practice accreditation programme includes training in the relevant legislation, business management issues and standards of practice, as identified in the evaluation instrument of the PhysioFocus practice accreditation programme. There are no courses offered to physiotherapists covering the topics mentioned above. These should therefore be included in structured workshops and in-service education. The services of an expert on these topics is required to structure the content of these courses. It is also imperative that a certificate of skill and competence and not only attendance, be issued. The courses should adhere to the criteria for a structured outcomes-based learning programme and attendees must be able to demonstrate competence.

5.7.3. Physiotherapy Management

Management theory and skills were not part of the basic training requirements of physiotherapists. This issue is presently being addressed by the Physiotherapy Standards Generating Board for inclusion in the future training programme for physiotherapy.

Activities in the physiotherapy practice should be structured either according to a management process of planning, organising, leading and control (Muller,

1998: 131); or according to the six generic functions of management (direction; planning; organising; finances; control; and policies and procedures). Traditionally the public sector utilises the generic process and the private sector, the management process. See Table 5.1. for the specific activities to be implemented by private physiotherapists according to the proposed management process.

Table 5.1. A Management Process for Private Physiotherapy Practice

Management Activity	Criteria
Planning	Philosophy/Mission
	Goals/Objectives
	Finances
	Disaster Planning
	Decision making
	Policies and Procedures
Organising	Delegation
	Job descriptions
	Organogramme
Leading	Leadership Style
	Communication
	Education/Training
	Conflict handling
	Discipline
	Motivation
	Personnel function
Control	Quality Improvement Programme – Standards
	Legal framework
	Infection Control
	Risk Management

Knowledge and skills are essential in implementing the management functions depicted in Table 5.1. It is therefore recommended that the current principals in private physiotherapy practice be trained in business management and utilise a consultant for the implementation of the business principles. There are a variety of business management courses available at university business schools, as well as at private education institutions.

5.7.4. Structured Quality Improvement Activities

It was clearly evidenced in the results of the questionnaires on the learning programme of the PhysioFocus practice accreditation programme that concepts

such as accreditation and quality improvement are new. They can therefore be very daunting and intimidating. The following statement is not only a reflection of current expectation of the nursing profession, but applies equally to the physiotherapy profession: " The knowledge and skills expected of today's nurse, is far more complex than was provided for in the basic training, especially if the training was completed several years ago. To remain clinically skilled, it is not an optional extra for nurses anymore, but in the current job market evidence of current practical skills will become a pre-requisite" (Van der Merwe et al., 1995: iv).

Quality improvement in private physiotherapy practice is a systematic process, with commitment from all individuals and the necessary support from management and the staff development department (Van der Merwe et al., 1995: v). This quality improvement process should be structured according to the needs of the patients, staff and the practice goals.

It is thus recommended that the critical factors, i.e. problem prone and high risk physiotherapy actions are identified and standards formulated. The identification of critical factors is necessary to implement quality physiotherapy actions. To initiate a quality improvement process, the following are required:

- Select a quality improvement committee.
- Formulate standards (staff members who are responsible for implementation of the standards should be involved in this process).
- Set a programme for the implementation of the standards (implement one or two standards at a time).
- Evaluate implemented standards against the actual work performance, according to a specific time and date period. Liase with the physiotherapy staff about the time frame.
- Implement a problem solving strategy for remediation methods in conjunction with physiotherapy staff.
- Evaluate and remediate all physiotherapy actions and activities continuously as a group effort in the practice.

- Utilise the final evaluation instrument (see Appendix two) for the continuous evaluation of future updates of PhysioFocus practice accreditation programmes.

5.7.5. Image of the Professional Physiotherapist

The questionnaire results on the learning programme of the PhysioFocus practice accreditation programme reflects the fact that physiotherapists are concerned about the public image of physiotherapy. Public opinion, though elusive, is a powerful factor influencing the customer's utilisation of physiotherapy care (Hein & Nicholson, 1986: 5). Any profession that seeks to serve the public must concern itself with public opinion. Public opinion has been and continues to be a powerful tool to promote change in society. In the light of the current public dissatisfaction with the health care system, physiotherapy has the opportunity to assume a more beneficial role in the delivery of health care. To ensure more efficient and effective utilisation of physiotherapy services, the public must be cognisant of and receptive to the actual and potential role of the physiotherapist in health care. Past history can provide insight into factors that have influenced past public opinion towards the physiotherapy profession. This knowledge can facilitate the physiotherapy profession's development in the future.

The physiotherapy profession has been aware of the need to maintain a well-educated and informed public. To be beneficial, however, public education must be a constant process that gives the public consistent and repetitive exposure to the physiotherapy profession. Lack of journalistic knowledge and insecurity in their literary ability, have often kept physiotherapists from attempting to communicate with the public through the press.

The importance of establishing a positive public image is especially important currently in South Africa. Debates about the crisis in health care delivery are common. As consumers of health care, the public and health funders are constantly expressing dissatisfaction with the high cost and poor quality of services available to them. This social climate will inevitably lead to changes in the health care delivery system. Because of the physiotherapist's intimate

association with the existing health care system, changes in the system will have direct bearing on the physiotherapy profession. Public opinion of the physiotherapist has had and will continue to have an effect on the ability of the physiotherapy profession to provide a unique and beneficial service to the public.

It is therefore recommended that physiotherapists should build up strong media contacts and educate media executives and personnel about physiotherapy today. Conferences that bring physiotherapists and media executives together to examine the image of physiotherapy are a very effective strategy to pursue. How the mass media react to physiotherapists and their concerns rests partly on how well physiotherapists understand the roles, functions and purposes of the media. If the physiotherapy profession believes it has a valuable service to offer in the area of health care delivery, this must be effectively communicated to the public through mass media. There is no-one more capable or better qualified than the physiotherapists themselves to inform the public of contributions the physiotherapy profession can make in the area of health care.

5.7.6. Future Research

It was evident from the evaluation of the PhysioFocus practice accreditation programme that future research should be based on the following hypotheses:

- The process of accreditation on private physiotherapy practice improves the image of the practice and the self image of the physiotherapist.
- Physiotherapists need to improve the public and health funder opinion in order to improve the image of the physiotherapy profession.
- The development and implementation of clinical standards for a specific physiotherapy practice will improve the quality of physiotherapy in that specific practice.
- The development and implementation of an outcomes-based physiotherapy management course will improve the quality of physiotherapy practice management.

- The implementation of scientific methods to evaluate and remediate physiotherapy outcomes and evidence-based treatment will improve the quality of physiotherapy.
- The utilisation of the final evaluation instrument in evaluating a physiotherapy practice accreditation programme will improve the quality of physiotherapy service delivery.

5.8. FINAL SUMMARY

"Quality" has different meanings to different people. Even quality experts do not agree on a single definition: Juran's definition of quality revolves around his concept of "fitness for use", Crosby defines quality in terms of performance that produces "zero defects" and Deming defines quality as a "never ending cycle of continuous improvement". One element, however, that is common to all three approaches is that management must accept and demonstrate leadership if quality is to be achieved.

Quality is rarely thought of as others perceive it. What is apparent is that if providers of care wish to maintain leadership in defining quality, they need to

- Actively participate in the public debate about quality.
- Review the way in which they have been defining quality.
- Question whether their definitions are aligned with what the purchasers of health care define as being important.
- Develop meaningful measures of quality and data collection systems that will allow them to demonstrate quality and value.
- Willingly share data not only on outcomes, and also measures that are specific to individual procedures and service providers.

The PhysioFocus practice accreditation programme attempted to achieve the above factors. By realising the goal of the research this was determined.

The goal of the research was to evaluate the PhysioFocus practice accreditation programme and to make recommendations on the educational programme for accreditation in private physiotherapy practices. This goal was realised by means of an exploratory and descriptive research design with a

qualitative orientation. The evaluation of the PhysioFocus practice accreditation programme was performed by means of a validated evaluation instrument. The group interview revealed components of the PhysioFocus practice accreditation programme that require remediation. Recommendations included professional-ethical issues, business management and legislative issues. The recommendations will be implemented by the PhysioFocus practice accreditation committee.

The PhysioFocus practice accreditation learning programme was evaluated by means of a semi-structured questionnaire, containing eleven questions and a section for comments. The general consensus was that the PhysioFocus practice accreditation programme is essential in private physiotherapy practice in South Africa. The implementation of the PhysioFocus practice accreditation programme resulted in the facilitation of quality physiotherapy; professional and personal development; monitoring of quality improvement processes; and the evaluation and remediation of these processes. This supported the central theoretical assumption of the research. Concerns were voiced about the lack of standards, the public image of the physiotherapy profession and the lack of basic business management training.

The researcher concluded that the implementation of the PhysioFocus practice accreditation programme is essential in private physiotherapy practice in South Africa. At present the current PhysioFocus practice accreditation programme does not address all the needs of private physiotherapy practices.

Recommendations generated from the research included remediation of the current PhysioFocus practice accreditation programme, formal education included business managements, professional-ethical-legal issues, standards and scientific methods to analyse process variation and the development of improvement strategies in quality improvement. Other recommendations included informal education, physiotherapy management and structured quality improvement activities. The issue of the image of the professional physiotherapist was also addressed. Topics for future research were identified.

The uniqueness of the research lies in the fact that this is the only physiotherapy practice accreditation programme implemented in South Africa. It is also the only physiotherapy practice accreditation programme in South Africa that has been evaluated.

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APPENDIX ONE: THE PROVISIONAL EVALUATION INSTRUMENT

Provisional Evaluation Instrument for an Accreditation Programme in Private Physiotherapy Practice

Compiled by: Winifred E Bowman (B.Sc. Physiotherapy, B.Sc. Hons Med, M.Sc. Med)

Instructions:

1. Review this provisional evaluation tool to be used for the evaluation of a physiotherapy accreditation programme. Please comment on suggested changes and/or additions.
2. Please tick in the applicable block.
3. Please tick all the blocks.
4. Key: C = compliance, PC = partial-compliance, A = absent.

Evaluation done by

Name and qualifications:
Date:

Thank you for your input.

General Summary:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Commendations:

Comments:

1. Foundations of professional physiotherapy practice in South Africa	**C**	**PC**	**A**
• Boundaries of exclusiveness are found in evidence of:			
- Specific training requirements			
- Practice standards			
- Registration			
• Theory and practical training includes:			
- Physical (physiotherapy science, applied physiotherapy, clinical physiotherapy)			
- Social (community) involvement			
- Business management			
• Evidence of registration with HPCSA			
• Evidence of membership of professional association			
• Evidence of standards from the Professional Board of Physiotherapy			
• Evidence of ethical rules			
• Evidence of disciplinary steps to be taken			
• Evidence of Scope of Practice			
• Evidence of accountability for Acts or Omissions			
• Evidence of a trust relationship			
• Evidence of transformation according to the health policy			
• Evidence of up to date knowledge			
• Evidence of knowledge of Hippocratic Oath			
• Evidence of sustained excellence through standards.			

2. Legislative framework for professional physiotherapy in South Africa	**C**	**PC**	**A**
Is the following in place and is there evidence of knowledge of the following:			
• SAQA Act 58 of 1998			
• Medical, Dental and Supplementary Health Services Act No 56 of 1974			
⇒ Scope of physiotherapy practice and specific procedures[section 33(1)]			
⇒ Acts or omissions [section 52(2)]			
• Employment Equity act No 55 of 1998			
• Health Act No 63 of 1977			
• Occupational Health and Safety Act No 85 of 1993			
• Human Tissue Act No 65 of 1983			
• Pharmacy Act No 53 of 1974			
• The Medical Schemes Act No 131 of 1998			
• Basic conditions of Employment Act No 75 of 1997			
• Commission for Occupational Injury and Diseases Act No 130 of 1993			
• Higher Education Act No 101 of 1997			
• Skills Development Act No 97 of 1998			

3. Outcomes-based Education (OBE)	**C**	**PC**	**A**
Is there evidence of knowledge and the implementation of OBE in training programmes:			
• Demonstration of outcomes			
⇒ High quality			
⇒ Culminating			
⇒ Significant learning			
⇒ Contextual			
• Outcome result/product present			
• Implementation of the four principles			
⇒ Clarity of focus			
⇒ Expanded opportunity			
⇒ High expectations			
⇒ Design down process			
• Specific learning areas/roles present			
• Exit outcomes present			
• Specific outcomes present			
• Purpose of OBE described			
• Emphasis described			
• Assessment principles implemented			
⇒ Summative (continuous monitor and feedback)			
⇒ Performance based (authentic)			
• Criterion-references (assessment criteria) available			
• Four criteria for assessment of competence (demonstration) described			
⇒ High quality			
⇒ At a culminating end point			
⇒ Show evidence of significant learning			
⇒ In context / performance setting			

4. Quality Improvement & Accreditation			
Is there any evidence of quality improvement activities in the training programme on accreditation?			
• Basic components include:			
⇒ Philosophy			
⇒ Value framework			
⇒ Mission			
• Principles to be implemented are a:			
⇒ Team approach			
⇒ Goal			
⇒ Applicable resources			
⇒ Critical factors			
⇒ Documentation			
⇒ Group pressure for change			
⇒Top management involved			
• Standards formulated according to:			
⇒ Structure			
⇒ Process			
⇒ Outcome			
• Standard formulation according to validity, reliability and a group effort			
• Performance monitoring and evaluation (audit and observation) available			
• Remedial actions in service documented			
• Dimensions of quality implemented in:			
⇒ Client quality			
⇒ Professional quality			
⇒ Management quality includes:			
❑ Planned services			
❑ Implementation done			
❑ Evaluation done			
• Infection control principles implemented			
• Patient education implemented			
• Broad approaches to quality implemented according to the services			
⇒ Exceptional			
⇒ Perfection			
⇒ Fit for purpose			
⇒ Value for money			
⇒ As transformation			
• QI programme implemented			
• QI committee established			
• QI model utilised			
• Performance evaluated according to:			
⇒ Quantity (eg. Number of patients seen)			
⇒ Quality according to:			
❑ Errors documented			
❑ Appearance observed (ie. patient interaction)			
⇒ Timeliness documented			
❑ Deadlines met			
❑ Absenteeism recorded			
❑ New approaches recorded			
❑ Cost-effectiveness analysed			
❑ 3 M's (money, men, materials) analysed			

APPENDIX TWO: FINAL EVALUATION INSTRUMENT

Evaluation Instrument for the PhysioFocus Practice Accreditation Programme for Private Physiotherapy Practice in South Africa

Compiled by: Winifred E Bowman (B.Sc. Physiotherapy, B.Sc. Hons Med, M.Sc. Med),

Date: July 2001.

Validated by:

Mr P Gorman (Registered physiotherapist, accreditation & outcomes expert)
Mr F Pretorius (Registered physiotherapist, accreditation expert)
Mr J Jaake (Registered physiotherapist, accreditation expert)
Mrs S Trueb (Registered physiotherapist, accreditation expert)
Ms L Scott (Registered physiotherapist, accreditation & practice management expert)

Instructions:

1. Use this evaluation tool for the evaluation of a physiotherapy accreditation programme for private practice in South Africa.
2. Please comment on suggested changes and/or additions.
3. Please place a tick in the applicable block.
4. Score: 3 = Exceed compliance
   2 = Compliance
   1 = Partial compliance
   0 = Absent

Total: _____ x 100
330

Percentage:

Evaluation done by
Name and qualifications:
Date:

Comments:

Recommendations:

1. STANDARD ONE: ORGANISATION AND ADMINISTRATION	3	2	1	0
***Statement*: The practice is organised and administered to provide optimum quality of care according to the objectives of the practice; to meet the needs of the patient population being served; and in accordance with the practice accreditation programme ethical principles, clinical standards and guidelines.**				
Is there any evidence of quality improvement activities in the training programme on accreditation in at least the following?				
• Basic components include:				
- A philosophy (value framework including a world view on the patient, illness, physiotherapy, staff and education)				
- A mission statement (includes the fundamental purpose of the practice)				
- Practice objectives (measurable goals to be met by the practice. These are time related – short, medium or long term goals)				
• Evidence of a regular communication system in place				
• Evidence of clear and legible clinical records				
• Risk management strategies (adequate insurance cover for staff & practice) in place				
• Evidence of monthly statistical records kept				
• Evidence of an annual financial statement and report system in place				
• Evidence of an effective account management system in place				
SUBTOTAL				

2. STANDARD TWO: STAFF DEVELOPMENT AND ADMINISTRATION	3	2	1	0
***Statement:* Practice objectives are achieved through appropriate staffing and direction. Staff shall participate in appropriate educational programmes that augment their knowledge and skills to complement the practice objectives.**				
Is there evidence of physiotherapy service being rendered according to the following criteria?				
• Theory and practical of basic physiotherapy training includes modules on the:				
- Physical (physiotherapy science, applied physiotherapy, clinical physiotherapy)				
- Social (community) involvement				
- Business management				
• Evidence of registration with HPCSA				
• Evidence of membership of professional association				
• Evidence of the existence of standards of practice from the Professional Board of Physiotherapy				
- Evidence of ethical rules				
- Evidence of a complaint and grievance procedure				
- Evidence of a disciplinary structure				
- Evidence of Scope of Practice				
- Evidence of accountability for Acts or Omissions				
• Evidence of a trust relationship (i.e. with patients, other health care workers)				
• Evidence of up to date knowledge (i.e. internal and external training)				
• Evidence of knowledge of Hippocratic Oath				
• Evidence of sustained clinical excellence through standards.				
• Principles to be implemented during training are according to:				
- A team approach				
- Goals (assess practice performance against each standard)				
- Applicable resources (3M's: money, men, materials) identified & effectively utilised				
- Critical factors (risk or problem areas) identified				
- Documentation of actions and negative incidents according to a specified system				
- An evaluation & remediation system in place				

2. STANDARD TWO: STAFF DEVELOPMENT AND ADMINISTRATION (cont)	3	2	1	0
Is there evidence of knowledge and the implementation of OBE in training programmes with at least the following?				
• Specific learning areas are documented according to identified individual learning needs				
• Purpose of OBE is documented				
• Implementation of OBE principles are evidenced by documented:				
- Clarity of focus (training course goals and objectives)				
- Expanded opportunity (increased and enhanced skills)				
- High expectations met (in practical implementation)				
- Design down process (decision making from top management to lowest employee levels)				
• Demonstration of outcomes are according to criteria of competence as evidenced by documentation of:				
- Quality (standards and remediation)				
- Culminating (practice implementation and skills)				
- Significant learning (implementation of skills)				
- Contextual (within the framework of the training)				
• Specific outcomes formulated (evidence of compliance) of specific skills / knowledge to be obtained				
• Exit outcomes formulated				
• Assessment principles implemented and evidenced in				
- Summative (continuous monitor and feedback) assessment criteria				
- Performance based (authentic) assessment criteria				
SUBTOTAL				

3. STANDARD THREE: POLICIES AND PROCEDURES	3	2	1	0
***Statement:* The operation of the practice complies with all practice accreditation programme ethical principles, clinical standards and guidelines and is consistent with relevant regulations and requirements of statutory authorities.**				
Are updated copies (amendments of Acts & regulations) of the following in place?				
• Medical, Dental and Supplementary Health Services Act No 56 of 1974				
• Health Act No 63 of 1977				
• Human Tissue Act No 65 of 1983				
• Pharmacy Act No 53 of 1974				
• The Medical Schemes Act No 131 of 1998				
• Commission for Occupational Injury and Diseases Act No 130 of 1993				
• Occupational Health and Safety Act No 85 of 1993				
• Basic conditions of Employment Act No 75 of 1997				
• Employment Equity act No 55 of 1998				
• SAQA Act 58 of 1995				
• Higher Education Act No 101 of 1997				
• Skills Development Act No 97 of 1998				
• Is there evidence of knowledge of at least the relevant aspects of the legislation?				
• Evidence of a policy and procedure manual (documentation of all aspects of patient care and administrative procedures for use by all staff as an ongoing reference. This document is also time related and must be continually updated)				
SUBTOTAL				

4. STANDARD FOUR: FACILITIES AND EQUIPMENT	3	2	1	0
***Statement*: Appropriate facilities and equipment are available for the efficient operation of the practice and for quality patient management.**				
Is the following in place?				
• Evidence of appropriate safety measures during patient treatment				
- Warning signs for cardiac pacemakers				
- Warning signs pertaining to heat treatment				
- Contraindications to certain modality of treatment documented				
- Buzzer/bell present in the absence of the physiotherapist				
- Where applicable, hydrotherapy safety and emergency policies documented				
• Adequately maintained equipment:				
- Documented evidence of the testing of electromedical equipment every two years				
- Record of dates of repairs, calibration & service of electromedical equipment				
• Evidence of a formal and scientific method of determining utilisation of equipment and stocks				
• Safe environment for staff and patients with at least the following in place:				
- Evidence of maintenance of all electrical outlets and wiring				
- Unobstructed passageway between service and utility areas				
- Appropriate lighting				
- Appropriate ventilation				
- Hygienic toilet and washing facilities				
- Appropriate room temperature				
• Provision of privacy for patients (curtains, doors, use of gowns)				
• Practice environment maintained in hygienic manner with appropriate infection control measures in place				
• Awareness of staff for the prevention and handling of potential dangers to patients and practice (fire, electrocution, cardiac arrest, hydrotherapy emergency)				
• An appropriate fire extinguisher present				
- Fire extinguisher appropriate for electrical and regular fires				
- Fire extinguisher must be easily accessible by all staff				
- Fire extinguisher must be serviced at least annually				
SUBTOTAL				

5. STANDARD FIVE: QUALITY MANAGEMENT	3	2	1	0
Statement: **The practice shall employ activities to apply quality management principles to the operation of the practice. These activities should relate to the practice objectives.**				
Is there any evidence of quality improvement activities in the training programme on accreditation on at least the following?				
• Dimensions of quality are implemented in:				
- A client quality (patient questionnaire) evaluation system in place				
- A professional quality (peer group) evaluation system in place				
- Quality management which includes:				
❑ Services are planned (organogramme, job descriptions, contracts, documented minutes of meetings, external and internal education programmes, induction and orientation programme for new employees, financial management strategies, risk management strategies, statistical records documented)				
❑ Practice manager implements participative management by means of:				
❖ Interactive decision making and problem solving				
❖ Management empowering of employees				
❖ Facilitating shared control				
❖ Organisational transformation: application of decision making systems				
❖ A formalised communication system				
❑ Implementation and evaluation of management strategies				
❑ Remediation of evaluated management strategies				
• A health care QI model is utilised				
• A QI committee is established to act on behalf of the practice				
• A QI programme is implemented and continually evaluated and updated				
• Standards are formulated according to:				
- Structure				
- Process				
- Outcome				
• Standard formulation are according to validity, reliability and a group effort				
• Standards are revised every two years				
• Standards reflect current practice				
• All standards are mandatory				
• Infection control principles are implemented and maintained				
• Documented evidence of implementation and maintenance of patient education				
• Practice performance is evaluated according to documented evidence of:				
- Quantity (number of patients treated per hour)				
- Quality is according to:				
❑ Documentation (all documentation including clinical records containing a detailed assessment, treatment goals and plans, with informed consent and warnings)				
❑ Practice activities observed (ie. patient interaction, telephone manner, general atmosphere)				
❑ Continuous QI activities are implemented and documented				
- Timeliness is documented according to:				
❑ Deadlines met				
❑ Absenteeism recorded				
❑ New approaches recorded				
❑ Cost-effectiveness analysed				
SUBTOTAL				

APPENDIX THREE: THE QUESTIONNAIRE

Evaluation of the Practice Accreditation Programme

Aim: This questionnaire is circulated to identify the positive and negative factors experienced during the implementation of the Practice Accreditation Programme. The information gathered will assist in future updates of the programme.

Personal Details:

1. You may remain anonymous.
2. Geographical location: _____
3. Do you subscribe to the Practice Accreditation Programme ethical principals, clinical standards and guidelines as well as the ethical principals, clinical standards and guidelines as set down from time to time by the SAPS and PhysioFocus?

_____

Instructions:

Please give your honest, detailed opinion in the spaces provided. Should the space provided be insufficient, use additional pages. Please make sure to number the answers on these additional pages.

1. What is your overall impression of the practice accreditation programme?

_____

_____

_____

_____

2. What are the positive aspects of the practice accreditation programme?

_____

_____

_____

3. What are the negative aspects of the practice accreditation programme?

_____

_____

_____

4. Do you think accreditation is appropriate in the current managed health care environment? _____

_____

5. Define accreditation in your own words. _____

_____

_____

6. Did you find the workbook helpful in your preparation? _____

_____

_____

7. Is specific training necessary for the use of this manual? _____ If Yes,

7.1 Who should do the training? _____

7.2 How long should the training be? _____

8.1. Was someone available to answer your queries about the implementation of the accreditation programme? 8.2. If so, who was available? _____

9. What is the value of accreditation in your practice? _____

_____

_____

_____

10. Will you recommend the practice accreditation programme to your colleagues? Please motivate your answer. _____

_____

_____

_____

11. What suggestions do you have for future upgrading of the practice accreditation programme? _____

_____

_____

_____

12. Any other comments: _____

_____

_____

Thank you for completing the questionnaire.